

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07215

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dam at R. Paul Smith Power Plant</u> <u>Potomac River</u>				e. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
f. STREET ADDRESS <u>1718 Virginia Ave.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>David</u> Middle <u>Lee</u> Last <u>Anderson</u>				4. DATE OF DEATH Month <u>June</u> Day <u>12</u> Year <u>19 61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 17 1944</u>	
9. AGE (In years last birthday) <u>16</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>25</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Public School</u>		11. BIRTHPLACE (State or foreign country) <u>Washington Co Md.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>							
13. FATHER'S NAME <u>Herbert Leo Anderson</u>				14. MOTHER'S MAIDEN NAME <u>Vivian Lorraine Robinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Herbert :ep Anderson</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Suffocation due to choking</u> 929.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u></u> (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>Tunnel</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Drowned while swimming in Potomac River</u>			
20c. TIME OF INJURY Month, Day, Year <u>6-12-1961</u> Hour <u>9:00</u> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Potomac River</u>		20f. (City or town) (County) (State) <u>Williamsport Wash. Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Edward W. Ditto III</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Edward W. Ditto III, MD</u>				M.D. ADDRESS (Street, city, town, or county) <u>Hagerstown Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>June 16-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Memorial Gardens</u>	
22d. LOCATION (City, town, or country) (State) <u>Hagerstown Md.</u>							
23. FUNERAL DIRECTOR <u>Albert L. Leaf Williamsport, Md</u>				24a. REC'D BY REGISTRAR <u>JUN 15 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Haines</u>	



1
Page 4
After death.
4 hours after death.
The law requires that the death certificate be executed within 4 hours after death.
The attending physician and completely filled in by the funeral director.
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7228

07216

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 53 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FREDERICK ARTHUR ANDREWS		4. DATE OF DEATH JUNE 11 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/30/1881
9. AGE (In years lost birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HORTICULTURIST		10b. KIND OF BUSINESS OR INDUSTRY FLORIST	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAMS ANDREWS		14. MOTHER'S MAIDEN NAME MARY JOHNSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-26-0065	
17. INFORMANT MR. GEORGE W. ANDREWS		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia DUE TO Chronic glomerulonephritis and Acute gastroenteritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Absence of ear due to carcinoma		INTERVAL BETWEEN ONSET AND DEATH 5 days indef. 5-30-61	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year June 11 1961		20d. INJURY OCCURRED While at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-1 1961, to death , that (I) (we) lost the deceased alive on 6-11 1961, and that death occurred on 6-11 from the causes and on the date stated above.			
22a. SIGNATURE Robert F. Keagle		22b. DATE SIGNED 6-12-61	
22c. PHYSICIAN'S NAME (Type) Robert F. Keagle		22d. ADDRESS Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/13/61	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		25a. REC'D BY REGISTRAR JUN 14 '61	
25b. REGISTRAR'S SIGNATURE John P. Jones			

TO BE FILLED BY THE ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7229
07217

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 3 Days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash County Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 227 So prospect St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) MARGARET ANN ANTHONY				4. DATE OF DEATH June 3 1961 19											
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec 23 1866		9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Cearfoss Wash Co Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Elder Nicholas Martin				14. MOTHER'S MAIDEN NAME Barbara Ann Neibert											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None				17. INFORMANT Miss Chloe Anthony 237 So Prospect St Hagerstown Md. Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (b) arteriosclerosis DUE TO (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												INTERVAL BETWEEN ONSET AND DEATH 1 day year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 5/28/61 to 6/3/61 , that (I) (we) last saw the deceased alive on 6/2/61 , and that death occurred 2:4 A.M. from the causes and on the date stated above.															
22a. SIGNATURE H.N. WEEKS				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/3/61							
22c. PHYSICIAN'S NAME (Type) H.N. WEEKS				22d. ADDRESS 136 N. Potomac HAGERSTOWN, MD.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/6/61		23c. NAME OF CEMETERY OR CREMATORY Dunkard Cemetery				23d. LOCATION (City, town or county) (State) Broadfording Wash Co Md					
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				ADDRESS		25a. REC'D BY REGISTRAR JUN 8 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kline							

00217

00217

(M)

(I)

W. W. N. E. C.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7230

07218

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY in 1b <u>2 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> d. STREET ADDRESS <u>154 N. Artizan Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Vida Blanche Arrington</u>			4. DATE OF DEATH Month Day Year <u>June 11 19 61</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 21 1909</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days <u>10 20</u>	IF UNDER 24 HRS. Hours Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Nurses Aid</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nursing Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Stroudsburg Pa.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles Wesley Dailey</u>			14. MOTHER'S MAIDEN NAME <u>Blanche Marion Smith</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 30 4420</u>		17. INFORMANT Address <u>154 N. Artizan St. Williamsport, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver failure from metastases</u> 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Abdominal carcinomatosis</u> DUE TO (c) <u>Rec. primary carcinoma of pancreas</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) (County) (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>May 15, 1961</u> , to <u>June 11, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 10, 1961</u> , and that death occurred at <u>8:20 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>John C. Stauffer</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED _____			
22c. PHYSICIAN'S NAME (Type) <u>JOHN C. STAUFFER, M.D.</u>				22d. ADDRESS <u>145 S. PROSPECT ST HAGERSTOWN, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 13-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn Memorial Gardens</u>			
23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williamsport, Md</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 14 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>William S. HARRIS</u>							

MEDICAL CERTIFICATION

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed in 24 hours after death. Pages may be retained by the hospital or attending physician. The law requires that the death certificate be completed in 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

CERTIFICATE OF DEATH

1920

(M)

State of New York, County of Westchester, City of Yonkers.

I, the undersigned, a duly qualified and licensed physician, do hereby certify that

on the 12th day of May, 1920, at the City of Yonkers, New York, died

of the disease of

the deceased, who was then residing at

the residence of the deceased, and that the deceased was at the time of death

in the full enjoyment of his or her mind and faculties, and that the deceased

was not at the time of death suffering from any legal disability, and that the

deceased was not at the time of death suffering from any legal disability, and that the

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deceased was not at the time of death suffering from any legal disability, and that the

(I)

May 12 1920

June 10 21

Witness my hand and the seal of my office this 12th day of May, 1920.

1
FOR STATE
HEALTH DEPT.

DR. DITTO
MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, any person may execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BENEVOLOA 'RURAL' d. STREET ADDRESS BOONSBORO MD. R-1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ALONG ROUTE 40 A		c. LENGTH OF STAY IN TB		f. DATE OF DEATH Month Day Year JUNE - 23 - 19 61	
3. NAME OF DECEASED (Type or print) ERNEST R. BAKER		4. DATE OF DEATH Month Day Year JUNE - 23 - 19 61		5. SEX MALE	
6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 18 - 1901	
9. AGE (In years last birthday) 59 yrs.		10. BIRTHPLACE (State or foreign country) ROXBURY WASH. Co. MD.		11. CITIZEN OF WHAT COUNTRY? U.S.A	
12a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TRUCK DRIVER - STATE ROAD COMMISSION		12b. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME DANIEL BAKER	
14. MOTHER'S MAIDEN NAME EMMA NIERTZ		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 216-14-6248	
17. INFORMANT MRS. ETHEL BAKER		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Atherosclerosis DUE TO (b) Thrombotic Occlusion of Ant. Descending Coronary DUE TO (c) Myocardial Infarction		INTERVAL BETWEEN ONSET AND DEATH Record def	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		22b. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22d. (City or town) (County) (State)		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 6/24/61	
24. ACTUAL SIGNATURE A. W. Ditt		24. EXAMINER'S NAME (Type) A. W. DITTO		25. DATE SIGNED 6/24/61	
26a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		26b. DATE THEREOF JUNE 26 1961		26c. NAME OF CEMETERY OR CREMATORY BENEVOLOA CEMETERY	
26d. LOCATION (City, town, or country) BENEVOLOA WASH. Co. MD.		27a. REC'D BY REGISTRAR DATE JUN 29 '61		27b. REGISTRAR'S SIGNATURE Arthur S. Huns	
28. FUNERAL DIRECTOR John A. East		28. ADDRESS BOONSBORO MD		29. DATE JUN 29 '61	

MEDICAL CERTIFICATION

MAXIMUM STATE DEPARTMENT OF MINES
BUREAU OF MINES, WASHINGTON, D. C.
MEDICAL EXAMINER, THE STATE OF OHIO

1915

100 100
100 100
M

100

[Faint, mostly illegible handwritten text, possibly a medical report or examination notes.]

7232

07220

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland,		0102-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. State Hosp.				d. STREET ADDRESS 113 Blaul Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Barbara Ellen BARNES		First Middle Last		4. DATE OF DEATH Month Day Year 6 24 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 8, 1886	
9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook,		11. BIRTHPLACE (State or foreign country) Artemas, Penna.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George W. Barnes		14. MOTHER'S MAIDEN NAME Sarah Jane Diehl		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No,		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Cora Appold 604 Fairview Ave., Cumb.		Address Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Cervix uteri with Metastasis DUE TO (c) Four years		INTERVAL BETWEEN ONSET AND DEATH One week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 24, 1961 to June 24, 1961 , that (I) was last saw the deceased alive on June 24, 1961 , and that death occurred at P. M. from the causes and on the date stated above.		22a. SIGNATURE Young E. Chun M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED June 24, 1961	
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN		22d. ADDRESS 1500 Penna. Ave. Hagerstown, Md		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/27/61	
23c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery,		23d. LOCATION (City, town, or county) (State) Artemas, Penna.		24. FUNERAL DIRECTOR'S SIGNATURE H. Wayne George		25a. REC'D BY REGISTRAR DATE JUN 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Frame							

(M)

(T)

RECEIVED
JANUARY 10 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
MEMORANDUM
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
[Illegible text follows, appearing to be a memorandum or report with multiple lines of text, some of which are partially obscured or illegible due to the quality of the scan.]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7233

07221

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>1 mo. 2 wks</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Maryland State Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Roy</u> First <u>Leslie</u> Middle <u>BECKLEY</u> Last				4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 19 1886</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u>11</u> Days <u>14</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Telegraph Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Penn. R. R.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Charles Elmer Beckley</u>				14. MOTHER'S MAIDEN NAME <u>Laura Ardinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>717 07 9339</u>		17. INFORMANT <u>Mrs. Mable G. Beckley</u> Address <u>Williamsport Md. R. F. D. #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of prostate</u> DUE TO (c) <u>4 years</u> INTERVAL BETWEEN ONSET AND DEATH <u>one week</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>April 19 1961</u> to <u>June 3 1961</u> , that (I) met last saw the deceased alive on <u>June 3 1961</u> , and that death occurred at <u>P. M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Young E. Chun</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>June 3 1961</u>			
22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>		22d. ADDRESS <u>1500 Penna. Ave. Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 7-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(1)

Ref: Leslie Beckley

CHURCH

THE CHURCH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7234

07222

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>8 Yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>517 No Mulberry St</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>517 No Mulberry St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ANETTA VIOLET BENNETT</u>		4. DATE OF DEATH <u>June 5 1961</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 12 1912</u> yrs. <u>48</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Pa. Fayette Co</u>
13. FATHER'S NAME <u>Nathan Divens</u>		14. MOTHER'S MAIDEN NAME <u>No Record</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Edgar Bennett</u>		Address <u>517 No Mulberry St Hagerstown Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.0 Hepatic Coma</u> DUE TO (b) <u>portal Cerebrosis</u> DUE TO (c) <u>3 weeks</u> Interval between ONSET and DEATH <u>3 weeks</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>None</u> 19 <u>19</u> p.m. <u>None</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) <u>-</u> (County) <u>-</u> (State) <u>-</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1961</u> , to <u>June 5, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 3, 1961</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>John D. Turco</u> M.D.		22b. DATE SIGNED <u>6-6-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. John D. Turco, M.D.</u>		22d. ADDRESS <u>302 N. Potomac St-Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/7/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) <u>Hagerstown Wash Co Md.</u> (State) <u>-</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		25a. REC'D BY REGISTRAR <u>JUN 8 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	
ADDRESS <u>Hagerstown Md.</u>		DATE <u>JUN 8 '61</u>	

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*Legation de France
Paris*

John Thomas

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the physician's signature and the signature of the funeral director, and the signature of the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4

VR A15 (4)
ISM 9/59

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7235

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07223

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
c. LENGTH OF STAY IN 1b 48 YRS.		d. STREET ADDRESS 617 HAYS AVE.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HELEN First IRENE Middle BICE Last		4. DATE OF DEATH JUNE Month 16 Day 19 Year 61	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/28/1900
9. AGE (In years lost birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) INDIANA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PHILIP B. HEEFNER		14. MOTHER'S MAIDEN NAME NELLIE V. MAUGANS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-0442	
17. INFORMANT MRS. LOIS JOAN STEVENS		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 171X DUE TO Carcinoma of cervix uteri Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)		INTERVAL BETWEEN ONSET AND DEATH 22	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 30, 1960 to June 16, 1961 , that (I) (we) last saw the deceased alive on June 16, 1961 , and that death occurred at 4 PM from the causes and on the date stated above.			
22a. SIGNATURE L. L. Packard Jr		22b. DATE SIGNED 6/17/61	
22c. PHYSICIAN'S NAME (Type) L. L. PACKARD JR		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/19/61	
23c. NAME OF CEMETERY OR CREMATORY WOLFVILLE U.B. CHURCH		23d. LOCATION (City, town, or county) (State) WOLFVILLE MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JUN 20 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Haines			

1933

CERTIFICATE OF DEATH

1933

M

DECEASED
DATE OF DEATH
PLACE OF DEATH

DATE OF BIRTH
PLACE OF BIRTH

SEX
MARRIAGE
OCCUPATION
EDUCATION

CAUSE OF DEATH
MANNER OF DEATH

SIGNATURE OF PHYSICIAN

SIGNATURE OF WITNESSES

SIGNATURE OF DECEASED

SIGNATURE OF REGISTRAR

SIGNATURE OF CLERK

SIGNATURE OF JUDGE

SIGNATURE OF SHERIFF

SIGNATURE OF CORONER

SIGNATURE OF DISTRICT ATTORNEY

SIGNATURE OF COUNTY CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 TO GENERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
 the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07224

7236

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>9400 Kanados Avenue</u>	
3. NAME OF DECEASED (Type or print) First <u>Virginia</u> Middle <u>Bond</u> Last <u>Bond</u>		4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 10, 1908</u>
9. AGE (In years last birthday) <u>53</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Greenburg Smith</u>		14. MOTHER'S MAIDEN NAME <u>Maryland Rachel Pratt</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) <u>214-36-4281</u>	
17. INFORMANT <u>Gladys Still (daughter)</u>		Address <u>Silver Spring, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>pulmonary embolus</u> 733X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>pathological fracture of rt hip</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u>8 hours</u> <u>1 month</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes, hypertension, & probable blood dyscrasia</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> p. m. <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>June 5</u> , 19 <u>61</u> , to <u>June 6</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>June 5</u> , 19 <u>61</u> , and that death occurred at <u>3:15 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>John J. Dobbie</u> M.D.		ADDRESS (Street, city or town, state) <u>115 King St.</u> DATE SIGNED <u>June 6, 1961</u>	
PHYSICIAN'S NAME (Type) <u>John J. Dobbie M.D.</u>		<u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>6/10/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Ash Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Sandy Spring, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Sumner</u> ADDRESS <u>Roe Kettle, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 9 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kneass</u>

MARYLAND STATE DEPT. OF HEALTH—BALTIMORE, 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7237

CERTIFICATE OF DEATH

Reg. Dist. No.

07225

1. PLACE OF DEATH o. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>W.VA.</u> b. COUNTY <u>PRESTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KINGWOOD</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. COUNTY HOSPITAL</u>		d. STREET ADDRESS <u>R.F.D. #1</u>	
3. NAME OF DECEASED (Type or print) First <u>BRYAN</u> Middle <u>N.M.N.</u> Last <u>BROADWATER</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 3 1961</u>
9. AGE (In years lost birthday) yrs. <u>3</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>30</u> Hours <u>30</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>JAMES ALBERT BROADWATER</u>		14. MOTHER'S MAIDEN NAME <u>DORIS JEAN COZAD</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MOTHER</u>		Address <u>KINGWOOD, W.VA.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetes</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Immaturity</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-3-61</u> , 19 <u>61</u> , to <u>6-3-61</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>6-3-61</u> , 19 <u>61</u> , and that death occurred at <u>8:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. D. Dove Jr.</u>		ADDRESS (Street, city or town, state) <u>214 N. Potomac</u>	
M.D. <u>DR. E. D. DOVE JR., HAGERSTOWN, MD.</u>		DATE SIGNED <u>6/9/61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/9/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Wash. Co. Hospital Lab</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Wash. Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. B. Turner, M.D. Wash. County Hosp</u>		24a. REC'D BY REGISTRAR <u>DATE JUN 12 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kinner</u>			

2081221XVO

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7238

07226

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Washington, D. C. b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) d. STREET ADDRESS 3070 Thayer Street N. E. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Dewey Lathrobe Brown		4. DATE OF DEATH Month 6 Day 18 Year 1961		5. SEX male	
6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 21, 1898	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 6 Days 18		11. IF UNDER 24 HRS. Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - U. S. Navy Yard			10b. KIND OF BUSINESS OR INDUSTRY Maryland		
11. BIRTHPLACE (State or foreign country) U. S. A.			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Albert Brown			14. MOTHER'S MAIDEN NAME Anna Elizabeth Shaw		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 218-34-7212		
17. INFORMANT Mrs. Nellie Brown (same as above) 2-d			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull - + cerebral DUE TO 8/6X Hemorrhage. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 8/6X DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) thrown from Auto when hit broadside by Another Car			
20c. TIME OF INJURY Month, Day, Year Hour 4:45 p.m. 6/18/1961		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Nr. Ringold - Rt # 64 Wash. Md	
20f. (City or town) (County) (State) Wash. Md					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Edward W. Dittus III		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/18/61	
EXAMINER'S NAME (Type) Edward W. Dittus III, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
Address (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/21/61		22c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
22d. LOCATION (City, town, or country) (State) Prince Georges Co, Md.					
23. FUNERAL DIRECTOR The S.H.Hines Co. Washington, D.C.		24a. REC'D BY REGISTRAR DATE JUN 23 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

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WINDS OVER

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Washington
Hennepin

Washington County Hospital

1070 Taylor Street S.E.

Washington, D.C.

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Miss White

Room 11, 11-8

Noted - U. S. Navy Yard

Building

about noon

(I)

Washington, D.C.

810-11-8
Miss White's Room (Room 11-8)

Washington, D.C.

Washington

Special Agent

The U.S. Navy Yard, Washington, D.C.

Washington County Hospital, Washington, D.C.

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7239

07227

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 3 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Smithsburg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 14 E. Water St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Elbra Middle Owen Last Brown				4. DATE OF DEATH Month June 18, Day 1961			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1, 1894	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 67		IF UNDER 24 HRS. Days 67 Hours 67 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) painter				10b. KIND OF BUSINESS OR INDUSTRY aircraft		11. BIRTHPLACE (State or foreign country) Euclid, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.							
13. FATHER'S NAME John D. Brown				14. MOTHER'S MAIDEN NAME Ellen R. Wagaman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes				16. SOCIAL SECURITY NO. WW I 217-03-2611		17. INFORMANT Mrs. Eula H. Brown, Smithsburg, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ARTERIOSCLEROTIC HEART DISEASE 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) GENERALIZED ARTERIOSCLEROSIS DUE TO lying cause lost. (c) UNKNOWN				INTERVAL BETWEEN ONSET AND DEATH 15 YEARS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Small Bowel obstruction, UREMIA				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from JUNE 15 19 61 , to JUNE 18 19 61 , that (I) (we) last saw the deceased alive on JUNE 17 19 61 , and that death occurred at 5:45 M, from the causes and on the date stated above.							
22a. SIGNATURE E. P. Lardizabal				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-18-61	
22c. PHYSICIAN'S NAME (Type) E. P. Lardizabal				22d. ADDRESS Smithsburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6-20-61		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.				25a. REC'D BY REGISTRAR JUN 21 '61		25b. REGISTRAR'S SIGNATURE Arthur S. ...	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

7240

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07228

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 5 MONTHS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MARYLAND STATE HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLINTON Middle F Last CHURCHIEY				4. DATE OF DEATH Month JUNE Day 5 Year 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 27 1916		9. AGE (In years last birthday) 45 yrs.	IF UNDER 1 YEAR Months 4 Days 8	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (State or foreign country) SHARPSBURG WASH. CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME OTHO E. CHURCHIEY				14. MOTHER'S MAIDEN NAME NORA J. TUCKER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213-18-8679		17. INFORMANT Address MRS. EDNA CHURCHIEY CLEARSPRING MD. R.1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH 10 minutes 7 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 1) Atherosclerosis obliterans 2) chronic atrial fibrillation							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 12-14 19 60 , to 6-5 19 61 , that (I) (we) last saw the deceased alive on 6-5 19 61 , and that death occurred at 11:30 M. from the causes and on the date stated above.							
22a. SIGNATURE Victor L. Ramos,		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED JUNE 6, 1961			
22c. PHYSICIAN'S NAME (Type) Victor L. Ramos, M.D.		22d. ADDRESS Western Md. State Hospital Hagerstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF JUNE 9, 1961	23c. NAME OF CEMETERY OR CREMATORY MOUNTAIN VIEW CEMETERY		23d. LOCATION (City, town, or county) (State) SHARPSBURG WASH. CO. MD.			
24. FUNERAL DIRECTOR'S SIGNATURE John H. Best		ADDRESS BOONSBORO MD		25a. REC'D BY REGISTRAR DATE JUN 12 '61		25b. REGISTRAR'S SIGNATURE William L. Hume	

1938

CERTIFICATE OF DEATH

(M)

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7241

07229

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>3 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>FUNKTOWN</u> d. STREET ADDRESS <u>111 STOFFER AVE</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>BENJAMIN F. CLARK</u>				4. DATE OF DEATH <u>JUNE - 20 - 1961</u>							
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 12 - 1884</u>					
9. AGE (in years last birthday) <u>77</u> yrs. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr> <td>IF UNDER 1 YEAR</td> <td>IF UNDER 24 HRS.</td> </tr> <tr> <td>Months <u>1</u> Days <u>8</u></td> <td>Hours <u>1</u> Min. <u>8</u></td> </tr> </table>		IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months <u>1</u> Days <u>8</u>	Hours <u>1</u> Min. <u>8</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED EMPLOYEE N.Y. CENTRAL IRON WORKS WASH. CO. MD.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
IF UNDER 1 YEAR	IF UNDER 24 HRS.										
Months <u>1</u> Days <u>8</u>	Hours <u>1</u> Min. <u>8</u>										
13. FATHER'S NAME <u>BENJAMIN F. CLARK</u>				14. MOTHER'S MAIDEN NAME <u>MARY JANE HARMAN</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>MRS. BLANCHE CLARK</u>							
17. INFORMANT <u>111 STOFFER AVE FUNKTOWN MD.</u>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> DUE TO (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) <u>Myocardial Infarction</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>June 7 - 1961</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Emphysema senile - Cor. Right Lung.</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>June 20, 1961</u> to <u>June 20, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 20, 1961</u> , and that death occurred at <u>5:40 AM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Sidney Novenstein</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>6-20-61</u>							
22c. PHYSICIAN'S NAME (Type) <u>SIDNEY NOVENSTEIN</u>				22d. ADDRESS <u>Funktown Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JUNE 23, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>HAGERSTOWN MD.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>John W. BAST</u>				25a. REC'D BY REGISTRAR <u>Boonsboro MD</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>					

THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXAMINED WITHIN 24 HOURS AFTER DEATH BY A HOSPITAL OR ATTENDING PHYSICIAN. THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXAMINED WITHIN 24 HOURS AFTER DEATH BY A HOSPITAL OR ATTENDING PHYSICIAN. THE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXAMINED WITHIN 24 HOURS AFTER DEATH BY A HOSPITAL OR ATTENDING PHYSICIAN.

DR. NOVENSTEIN

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72-hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH										
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 4 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Clarksburg d. STREET ADDRESS Box 1 e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Bobby Eugene Coffey			4. DATE OF DEATH June 15 19 61		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Nursery		11. BIRTHPLACE (State or foreign country) Kings Mt. N. C.		9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME James Coffey					14. MOTHER'S MAIDEN NAME Edna Breakfield					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes give number or date of service)		17. INFORMANT Address Mrs. Edna Coffey Clarksburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture neck. 902.8 DUE TO (b) (C3-C5-C6 cervical vertebrae) Conditions, if any, which gave rise to immediate cause (c) 902.8 (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Dived 25 feet into shallow (4ft) water							
20c. TIME OF INJURY Month, Day, Year 6 11 19 61			20d. INJURY OCCURRED at work <input type="checkbox"/> Not at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Monocacy River		20f. (City or town) Clarksburg (County) Mont. (State) Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Edward W. Ditto III			EXAMINER'S NAME (Type) Edward W. Ditto III		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/16/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 6-17-61		22c. NAME OF CEMETERY OR CREMATORY Clarksburg Cemetery		22d. LOCATION (City, town, or country) (State) Clarksburg, Md.			
23. FUNERAL DIRECTOR ADDRESS Scott F. Minnich & Son Hagerstown, md.					24a. REC'D BY REGISTRAR JUN 19 61		24b. REGISTRAR'S SIGNATURE Arthur L. Huns			

2 for 1 6/19/61 mh Film G288

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
7243 CERTIFICATE OF DEATH 07231													
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>9 Weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>906 Pope Ave</u>						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>2003 Jefferson Blvd</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>CHARLES EDWARD COMER</u>						4. DATE OF DEATH Month Day Year <u>June 16 1961</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 17 1886</u>		9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Penna R.R.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Luray Paige Co Va.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward Comer</u>						14. MOTHER'S MAIDEN NAME <u>Georgiana Burner</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>						16. SOCIAL SECURITY NO. <u>717-07-9304</u>						17. INFORMANT <u>Lawson Burner Funkstown Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. myocardial Infarction</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>general arteriosclerosis and</u> DUE TO (c) <u>arteriosclerotic heart disease</u>										INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m.		Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug. 1960</u> , 19 <u>60</u> , to <u>June 16</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>June 2</u> , 19 <u>61</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Edward W. Ditto III</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6/16/61</u>					
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto III, M. D.</u>						22d. ADDRESS <u>217 West Washington St.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/19/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Wash Co Md.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman Hagerstown Md.</u>						25a. REC'D BY REGISTRAR DATE <u>JUN 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>					

VR A15 (4)
15M 9/60

1032

OFFICE OF THE ATTORNEY GENERAL

1032



IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the Office of the Attorney General at the City of Washington, D.C., this 10th day of June, 1907.

JOHN C. BROWN, Attorney General

1032

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07232

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hancock Rest Home</u>				d. STREET ADDRESS <u>145 W. Main St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>Byrd</u> Last <u>Cornelius</u>				4. DATE OF DEATH Month <u>6</u> Day <u>12</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/2/1873</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Hancock, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>			
13. FATHER'S NAME <u>William S. Cornelius</u>				14. MOTHER'S MAIDEN NAME <u>Mary Catherine Dyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Mrs. Mary Exline</u>				Address <u>Hancock, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.1</u> DUE TO <u>Cardiovascular</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic disease</u> DUE TO (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>5/15</u> 19 <u>61</u> to <u>6/12</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6/12</u> 19 <u>61</u> , and that death occurred at <u>4:17</u> M. from the causes and on the date stated above.				22a. SIGNATURE <u>M Shaffer</u>			
22c. PHYSICIAN'S NAME (Type) <u>E M SHAFFER</u>				22b. DATE SIGNED <u> </u>			
22d. ADDRESS <u>Hancock Md</u>				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>6/15/61</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Episcopal</u>				23d. LOCATION (City, town, or county) (State) <u>Hancock Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J Stone</u>				25a. REC'D BY REGISTRAR <u> </u> DATE <u>JUN 19 61</u>			
25b. REGISTRAR'S SIGNATURE <u>William S. Stone</u>				25c. DATE <u> </u>			

2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 2683, 2684, 2685, 2686, 26

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

7245

07233

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg		c. LENGTH OF STAY IN 1b 82 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 206 W. antietam Street		d. STREET ADDRESS 206 W. Antietam St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thomas Albert Crampton		4. DATE OF DEATH June 7 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 13 1878
9. AGE (In years last birthday) 82		10. IF UNDER 1 YEAR Months 8 Days 24	
11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Game Warden Conservation		10b. KIND OF BUSINESS OR INDUSTRY Maryland State	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Crampton		14. MOTHER'S MAIDEN NAME Francis E. Saylor	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Thomas Edgar Crampton		Address 206 W. Antietam St. Sharpsburg Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute lymphatic leukemia 204.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH 2 months MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 4/11/61 19 to 6/7/61 19, that (I) (we) last saw the deceased alive on 6/11/61 19, and that death occurred at 9 PM, from the causes and on the date stated above. 22a. SIGNATURE Walter H. Shealy M. D. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 6/9/61 22c. PHYSICIAN'S NAME (Type) Walter H. Shealy M. D. 22d. ADDRESS Sharpsburg, Md. 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF June 10-61 23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery 23d. LOCATION (City, town, or county) (State) Sharpsburg Md. 24. FUNERAL DIRECTOR'S SIGNATURE Albert Lee Williams ADDRESS DATE JUN 12 '61 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07234

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 10 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ELmer Middle Richard Last CREBBS				4. DATE OF DEATH Month 6 Day 3 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-2-1886	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Truck Farmer			10b. KIND OF BUSINESS OR INDUSTRY Frederick Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John D. Crebbs			14. MOTHER'S MAIDEN NAME Margaret L. Holzapfel				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-03-6589		17. INFORMANT Raymond Crebbs Address Rt. # 7 Frederick, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Essential hypertension DUE TO (c) unknown						INTERVAL BETWEEN ONSET AND DEATH one month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from May 24, 1961 to June 3, 1961 , that (I) last saw the deceased alive on June 3, 1961 , and that death occurred at A. M. from the causes and on the date stated above.							
22a. SIGNATURE Young E. Chun		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED June 3, 1961				
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN		22d. ADDRESS 1500 Penna Ave Hagerstown Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6-6-1961	23c. NAME OF CEMETERY OR CREMATORY Pleasant Hill Cemetery		23d. LOCATION (City, town, or county) (State) Frederick Co., Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey & Son		ADDRESS Frederick, Maryland		25a. REC'D BY REGISTRAR JUN 6 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

8
1
BP



1948

CERTIFICATE OF DEATH

1948

Registration District: ...
Date of Death: ...
Place of Death: ...

FLORIAN CRONOS

Age: ...
Sex: ...
Marital Status: ...

Signature of Registrar: ...

Signature of Deceased: ...

Signature of Next of Kin: ...

Signature of Medical Officer: ...

Signature of Coroner: ...

Signature of Police Officer: ...

Signature of ...: ...

Signature of ...: ...

Signature of ...: ...

Signature of ...: ...

Signature of ...: ...

Signature of ...: ...

Signature of ...: ...

Signature of ...: ...

1
FOR STATE
HEALTH DEPT. **M**
099
TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
VS. A1SME
5M 7/59

7247
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07235

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pleasantville d. STREET ADDRESS Hoffmaster Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELLEN LUCINDA DILLOW		4. DATE OF DEATH Month Day Year June 25, 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 25, 1906
9. AGE (In years last birthday) 54		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Samples Manor, Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Barton Hanes	
14. MOTHER'S MAIDEN NAME Annie Weaver		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Virgie Mae Carey Brownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 490X LOBULAR PNEUMONIA, BILATERAL DUE TO W/ABSCESS FORMATION (b) DEHYDRATION DUE TO (c) BARBITURATE INTOXICATION?		INTERVAL BETWEEN ONSET AND DEATH 3 DAYS 5 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>[Signature]</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) DR. E. W. DITTO, JR.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6/25/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/28/61	
22c. NAME OF CEMETERY OR CREMATORY Samples Manor Cemetery		22d. LOCATION (City, town, or country) (State) Samples Manor, Maryland	
23. FUNERAL DIRECTOR <i>[Signature]</i>		24a. REC'D BY REGISTRAR JUN 27 '61	
24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

LOWE
M

I

DR. E. W. CITTO, JR.

BARBITURATE INTOXICATION?

DEHYDRATION

WABCESS FORMATION

LOBULAR PNEUMONIA, BILATERAL

3 DAYS

2 DAYS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07236**

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN			c. LENGTH OF STAY IN 1b 3 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X RURAL HAGERSTOWN		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RT.#1 HAGERSTOWN				d. STREET ADDRESS RT.#1 HAGERSTOWN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle DOCHERTY Last				4. DATE OF DEATH Month JUNE Day 17 Year 1961			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/15/1882	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALESMAN	
10b. KIND OF BUSINESS OR INDUSTRY FLOOR COVERINGS		11. BIRTHPLACE (State or foreign country) SCOTLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JAMES DOCHERTY				14. MOTHER'S MAIDEN NAME CHRISTINIA JAMESON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO.		17. INFORMANT (Address) MR. ROBERT DOCHERTY BALTIMORE MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>General arterio-sclerosis and</u> (c), stating the underlying cause lost. <u>arterio-sclerotic heart Disease</u>							INTERVAL BETWEEN ONSET AND DEATH <u>Turned</u> <u>15 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>. Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>.							
ACTUAL SIGNATURE <u>Edward W. Ditto III, M.D.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/18/61	
EXAMINER'S NAME (Type) <u>Edward W. Ditto III, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 6/20/61		22c. NAME OF CEMETERY OR CREMATORY LAWN CROFT CEM.		22d. LOCATION (City, town, or county) (State) LINWOOD PENNA.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Korman, Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR DATE JUN 20 '61		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If on duty, it may be necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07237

7249

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 121 E. Main Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Arthur Howell Dorsey				4. DATE OF DEATH Month Day Year June 21 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 21 1894		9. AGE (In years last birthday) yrs. 66	10. IF UNDER 1 YEAR Months Days 10 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vice President & Cashier Bank		10b. KIND OF BUSINESS OR INDUSTRY Sharpsburg Md.		11. BIRTHPLACE (State or foreign country) U.S.A		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Charles Christian Dorsey				14. MOTHER'S MAIDEN NAME Anna Martha Stine			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. #1 216 07 7098		17. INFORMANT Address Mrs. Edna Dorsey 121 E. Main St. Sharpsburg Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia - terminal 502.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema and chronic bronchitis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic myocarditis.						INTERVAL BETWEEN ONSET AND DEATH 3 Days 3 Yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from 1958 to 6/21/61 , 19____, that (I) (we) last saw the deceased alive on 6/21/61 , 19____, and that death occurred at 4p M, from the causes and on the date stated above.							
22a. SIGNATURE Walter H. Shealy				22b. DATE SIGNED 6/23/61		22c. PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.	
22d. ADDRESS Sharpsburg, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 24-61		23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City, town, or county) (State) Sharpsburg Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leg Williamsport, Md				25a. REC'D BY REGISTRAR JUN 26 '61		25b. REGISTRAR'S SIGNATURE Charles S. Kraus	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1933

CERTIFICATE OF DEATH

10

Respiratory and chronic bronchitis
Broncho-pneumonia - terminal

Chronic pyelitis.

1933

1933

1933

1933

Shawbury, W.

Walter E. Sherry M. D.

1
FOR STATE
HEALTH DEPT.

TO THE DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
7250 07238											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown, Md. c. LENGTH OF STAY IN b 11 yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Dead on arrival Washington County Hosp.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 03 Hagerstown, Maryland. d. STREET ADDRESS 130 W. Bethel Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Luther Edward Dorsey						4. DATE OF DEATH June 12 19 61					
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 16 1913		9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clergyman				10b. KIND OF BUSINESS OR INDUSTRY Church				11. BIRTHPLACE (State or foreign country) Cooksville, Md.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Joseph Dorsey						14. MOTHER'S MAIDEN NAME Maria Prettyman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) no						16. SOCIAL SECURITY NO. 212-14-5853					
17. INFORMANT Mrs. Dorothy Dorsey						Address 130 W. Bethel St.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 434.4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Atherosclerosis, Severe DUE TO (c) Cardiac Hypertrophy PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Instant											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 6-13-61											
ACTUAL SIGNATURE [Signature] EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.						ADDRESS (Street, city, town, or county)					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6-18-1961		22c. NAME OF CEMETERY OR CREMATORY Mt. Gregory Cemetery		22d. LOCATION (City, town, or country) (State) Cookesville, Md.					
23. FUNERAL DIRECTOR John R Watson Jr. Hagerstown Md.						24a. REC'D BY REGISTRAR JUN 19 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Huns			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
7251
CERTIFICATE OF DEATH
07239

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING c. LENGTH OF STAY IN 1b OVER 50 YRS. d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION S. MILL ST.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING, MD. d. STREET ADDRESS CUMBERLAND ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY LOOSE DOWNS		4. DATE OF DEATH Month Day Year JUNE 30 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 22, 1879
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 8 8	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME DUTIES		10b. KIND OF BUSINESS OR INDUSTRY HOUSE WORK	
11. BIRTHPLACE (State or foreign country) PEABODY, KANSAS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DR. CYRUS LOOSE		14. MOTHER'S MAIDEN NAME ALICE SPANGLER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT CHARLES DOWNS		Address CLEAR SPRING, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction to coronary artery occlusion 420.0 DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture hip right, due to fall at home 20 May 1961		INTERVAL BETWEEN ONSET AND DEATH 30 minutes 15 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) Fell at home... 20 May 1961		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 8:30 a.m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Clear Spring Washington Md.	
21. I certify that (I) (this hospital) attended the deceased from 20 May 1961 to 30 June 1961 , that (I) (we) last saw the deceased alive on 30 June 1961 19, and that death occurred at 11:55 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <i>Archie Robert Cohen</i> M.D.		22b. DATE SIGNED 2 July 1961	
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.		22d. ADDRESS Clear Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JULY 3, 1961	
23c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEMETERY		23d. LOCATION (City, town, or county) (State) ST. PAUL, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Margaret Rowland</i> ADDRESS CLEAR SPRING, MD.		25a. REC'D BY REGISTRAR JUL 5 '61	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kram</i>			

CERTIFICATE OF DEATH

1921

(M)

STATE OF NEW YORK, COUNTY OF NEW YORK, CITY OF NEW YORK.

I, the undersigned, a duly qualified and licensed physician, do hereby certify that

on the _____ day of _____, 1921, at _____, New York City, New York,

_____ died, of _____, at _____, New York City, New York.

Witness my hand and the seal of my office, this _____ day of _____, 1921.

_____ M.D.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7252

07240

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 30 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1827 Sheridan Ave.				e. STREET ADDRESS 1827 Sheridan Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First		Middle		Last	
Olla		Victoria		Edwards			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 21, 1895	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stitcher		10b. KIND OF BUSINESS OR INDUSTRY Shoe Factory		11. BIRTHPLACE (State or foreign country) Woodstock, Va.		12. CITIZEN OF WHAT COUNTRY? 	
13. FATHER'S NAME Harvey Hoffman				14. MOTHER'S MAIDEN NAME Margaret Dunkin			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-09-0471		17. INFORMANT Mr. Robert E. Edwards Address Hagerstown, md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 162-1 DUE TO Brochogenic carcinoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 23, 1961 , to June 24, 1961 , that (I) (we) last saw the deceased alive on June 24, 1961 , and that death occurred at 9p.M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Walter Layman</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED June 26, 1961			
22c. PHYSICIAN'S NAME (Type) W. Walter Layman, M. D.,		22d. ADDRESS 100 Professional Arts Bldg., Hagerstown, Maryland.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-27-61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				25a. REC'D BY REGISTRAR JUN 27 1961		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

14

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7253

07241

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last TREBE CLYDE ERNDE		4. DATE OF DEATH Month Day Year JUNE 7 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/11/1889
9. AGE (In years last birthday) 72 rs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED WATER DEPT. PUMPING STATION		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME LEWIS ERNDE		14. MOTHER'S MAIDEN NAME EMMA TRACEY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-09-4725	
17. INFORMANT MISS MAXINE ERNDE		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 260X DUE TO Arteriosclerosis general Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus DUE TO (c) Gangrene - Rt foot		INTERVAL BETWEEN ONSET AND DEATH 4 days 1 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 18 1961 to June 7th 1961 , that (I) (we) last saw the deceased alive on June 7th 1961 , and that death occurred at 10 PM , from the causes and on the date stated above.			
22a. SIGNATURE Philip J. Hirshman		22b. DATE SIGNED 6/8/61	
22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		22d. ADDRESS 159 W. Washington St. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/9/61	
23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		25a. REC'D BY REGISTRAR JUN 12 '61	
ADDRESS Hagerstown, Md		25b. REGISTRAR'S SIGNATURE Carlton L. Finner	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07243

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>2 Days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>106 Parke Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARGARET LOUISE EWALD</u>		4. DATE OF DEATH Month Day Year <u>June 16 1961 19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 18 1884</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home Service Dept P. E. Co Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mt Savage Allegany Co</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Ewald</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Kimmel</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <u>214-10-5502</u>	
17. INFORMANT <u>Edawrd Ewald</u>		Address <u>84 Frost Ave Frostburg Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Internal injuries + multiple</u> 830X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>rib fractures + fracture of left femur - (complete transverse)</u> DUE TO (c) <u>fracture of left femur - (complete transverse)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Injured when Auto backed over her -</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Injured when Auto backed over her -</u>	
20c. TIME OF INJURY Month, Day, Year Hours <u>9</u> a.m. <u>June 13, 1961</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>2209 Rolling Rd Hagerstown Md</u>		20f. (City or town) (County) (State) <u>Hagerstown wash Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Edward W. Ditto III</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Edward W. Ditto III, M. D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/18/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt Savage Meth Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Mt Savage Allegany Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>DATE JUN 20 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

DATE SIGNED

6/16/61

ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

PART OF DEATH REPORT		DEATH OF DECEASED	
NAME OF DECEASED _____		SEX _____	
AGE _____		RACE _____	
DATE OF DEATH _____		TIME OF DEATH _____	
PLACE OF DEATH _____		CAUSE OF DEATH _____	
MANNER OF DEATH _____		MEDICAL HISTORY _____	
OCCASION OF DEATH _____		SIGNATURE OF EXAMINER _____	
SIGNATURE OF WITNESS _____		SIGNATURE OF DECEASED _____	
SIGNATURE OF NEXT OF KIN _____		SIGNATURE OF BURIAL SOCIETY _____	
SIGNATURE OF MINISTER OF THE GOSPEL _____		SIGNATURE OF CLERGYMAN _____	
SIGNATURE OF JUDGE OF THE COURT _____		SIGNATURE OF DISTRICT ATTORNEY _____	
SIGNATURE OF SHERIFF _____		SIGNATURE OF CLERK OF THE COURT _____	
SIGNATURE OF JURY _____		SIGNATURE OF JUDGE OF THE COURT _____	
SIGNATURE OF DISTRICT ATTORNEY _____		SIGNATURE OF CLERK OF THE COURT _____	
SIGNATURE OF SHERIFF _____		SIGNATURE OF CLERGYMAN _____	
SIGNATURE OF MINISTER OF THE GOSPEL _____		SIGNATURE OF BURIAL SOCIETY _____	
SIGNATURE OF NEXT OF KIN _____		SIGNATURE OF OCCASION OF DEATH _____	
SIGNATURE OF MANNER OF DEATH _____		SIGNATURE OF MEDICAL HISTORY _____	
SIGNATURE OF PLACE OF DEATH _____		SIGNATURE OF DATE OF DEATH _____	
SIGNATURE OF SEX _____		SIGNATURE OF RACE _____	
SIGNATURE OF NAME OF DECEASED _____		SIGNATURE OF PART OF DEATH _____	

(M)

(1)

ALABAMA STATE DEPARTMENT OF HEALTH - BIRMINGHAM 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7255

07244

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 9 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First HELEN Middle IRENE Last FORD				4. DATE OF DEATH Month JUNE Day 28 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 2, 1924	9. AGE (In years last birthday) yrs. 36	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Point of Rocks, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Quincy Lowery				14. MOTHER'S MAIDEN NAME Lena Dean			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. Unk		17. INFORMANT James S. Ford, Sr. Adamstown, Maryland.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 171X IMMEDIATE CAUSE (a) Pulmonary hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Pulmonary metastasis DUE TO (c) carcinoma of cervix						INTERVAL BETWEEN ONSET AND DEATH 5 min. unknown 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0 Hydronephrosis						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Point of Rocks	(County) Maryland	(State) Maryland		
21. I certify that (I) (this hospital) attended the deceased from JUNE 19, 1961 , to JUNE 28, 1961 , that (I) (we) last saw the deceased alive on JUNE 28, 1961 , and that death occurred at 5:48 PM , from the causes and on the date stated above.							
22a. SIGNATURE Victor L. Ramos, M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED JUNE 29, 1961			
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS, M.D.		22d. ADDRESS Western Maryland State Hospital Hagerstown, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 3, 1961	23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery.	23d. LOCATION (City, town, or county) Point of Rocks,	(State) Maryland.			
24. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son, 106 E. Church St. Frederick, Md.			25a. REC'D BY REGISTRAR DATE JUL 3 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1935

UNITED STATES OF AMERICA

Washington

Department

State

Office of

Public Affairs

Room

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Room 100

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Room 100

Room 100

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7255
CERTIFICATE OF DEATH

07245

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 45 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 428 W. Franklin Street			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 428 W. Franklin Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ABRAHAM Middle FREDERICK Last FOREMAN, JR.			4. DATE OF DEATH Month June Day 23 Year 1961		
5. SEX male			6. COLOR OR RACE white		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			8. DATE OF BIRTH February 26, 1894		
9. AGE (In years last birthday) 67 yrs.			IF UNDER 1 YEAR Months 67 Days 0		
IF UNDER 24 HRS. Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Construction worker Contractor			10b. KIND OF BUSINESS OR INDUSTRY Shady Grove, Pennsylvania U.S.A.		
11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Abraham Frederick, Foreman, Sr.			14. MOTHER'S MAIDEN NAME Cornelia Loy		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. W.W. I 217-10-3439		
17. INFORMANT Mrs. Winona Ridenour			Address Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma (Rt Lung) 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 1 yr +		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Feb 1 , 19 61 , to June 23 , 19 61 , that (I) (was) last saw the deceased alive on June 22 , 19 61 , and that death occurred at 9 AM , from the causes and on the date stated above.					
22a. SIGNATURE F.F. Lusby			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) F.F. Lusby			22d. ADDRESS 230 N Potomac St Hagerstown Md		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6/26/1961		
23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery			23d. LOCATION (City, town or county) (State) Greencastle Pa.		
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home			ADDRESS Hagerstown, Md.		
25a. REC'D BY REGISTRAR JUN 28 '61			25b. REGISTRAR'S SIGNATURE Arthur S. House		

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7257

07246

1. PLACE OF DEATH a. COUNTY MARYLAND Washington				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION West High Street				d. STREET ADDRESS West High Street 1			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Annie Middle Louise Last French				4. DATE OF DEATH Month 6 Day 25 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/25/1874	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Big Pool, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME William Manning				14. MOTHER'S MAIDEN NAME Amelia Otto			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Gant Johnson		Address Big Pool, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Passive Heart Failure 420.0 DUE TO 8 hrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Acute Myocardial Infarction DUE TO 8 hrs (c) Arteriosclerotic Heart Disease DUE TO 15 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 6-29 , 19 61 , to 6-25 , 19 61 , that (I) was lost saw the deceased alive on 6-25 , 19 61 , and that death occurred 2-25 M, from the causes and on the date stated above.							
22a. SIGNATURE F.B. Thomas III M.D.				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-27-61	
22c. PHYSICIAN'S NAME (Type) F.B. THOMAS III M.D.				22d. ADDRESS HANCOCK, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/28/61		23c. NAME OF CEMETERY OR CREMATORY Shanks Town EUB		23d. LOCATION (City, town, or county) (State) Shank Town Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard J. Elmer Hancock Md				25a. REC'D BY REGISTRAR JUN 29 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7258

07247

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb most of life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jackson Convalescent Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 136 Broadway e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDITH Middle ALMA Last FUNKHOUSER				4. DATE OF DEATH Month June Day 6 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 14, 1876	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 84 Days 84		IF UNDER 24 HRS. Hours 84 Min. 84			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Winchester, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Marcus J. Snapp				14. MOTHER'S MAIDEN NAME Zora V. Gay			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT George D. Funkhouser Address Hagerstown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive cardiovascular disease DUE TO (c) Indefinite						INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 4 1961 to June 6 1961 that (I) (we) last saw the deceased alive on June 4 1961 , and that death occurred at 3:40 A.M. from the causes and on the date stated above.							
22a. SIGNATURE B. B. Kneisley M.D.				22b. DATE SIGNED 6/7/61			
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.				22d. ADDRESS 148 West Washington Street Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/8/1961		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home				25a. REC'D BY REGISTRAR June 12 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Kneis							

TO INITIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7259

07248

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 6 Hrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash County Hospital				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 901 Chestnut St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DAVID ALBERT GOSSARD				4. DATE OF DEATH Month June Day 19 Year 1961			
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 22 1877	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 84 Days 19		IF UNDER 24 HRS. Hours 19 Min. 19			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Hag dairy Co		11. BIRTHPLACE (County & State, or foreign country) Welsh Run Franklin Co Pa.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Theodore Gossard				14. MOTHER'S MAIDEN NAME Josephene Barnes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 214-09-2837		17. INFORMANT Address Mrs Myrtle M. Gossard 901 Chestnut St Hagerstown Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary atherosclerosis (c) Generalized atherosclerosis				INTERVAL BETWEEN ONSET AND DEATH 8 hours Unknown Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 15 , 19 52 to June 19 , 19 61 , that (I) (we) last saw the deceased alive on June 19 , 19 61 , and that death occurred at 3:15 PM , from the causes and on the date stated above.							
22a. SIGNATURE L L Parker J				22b. DATE SIGNED 6/19/61		22c. ADDRESS M.D.	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/21/61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				25a. REC'D BY REGISTRAR JUN 22 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07249

7260

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b X Rural - Smithsburg d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Rural - Smithsburg d. STREET ADDRESS RD # 2	
3. NAME OF DECEASED (Type or print) First Nellie Middle Elizabeth Last GRABLE		4. DATE OF DEATH Month 6 Day 26 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1897
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months 6 Days 26 Hours 19 Min.	IF UNDER 24 HRS. Months 6 Days 26 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Hahn	
14. MOTHER'S MAIDEN NAME Harriett Bostic		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. Unknown		17. INFORMANT Robert C. Hahn, Greensburg, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of sigmoid colon with Metastasis 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease			INTERVAL BETWEEN ONSET AND DEATH 3 years
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from April 6, 1961 to June 26, 1961 , that (I) was last saw the deceased alive on June 26, 1961 , and that death occurred at P. M. from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun M.D.		22b. DATE SIGNED June 26, 1961	
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN		22d. ADDRESS 1500 Penna. Ave. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 6/29/1961	23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery	23d. LOCATION (City, town, or county) (State) Cascade Maryland
24. FUNERAL DIRECTOR'S SIGNATURE S. Marlin Roe ADDRESS Waynesboro, Penna.		25a. REC'D BY REGISTRAR JUN 28 '61	25b. REGISTRAR'S SIGNATURE Arthur L. Kline

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 of this certificate is to be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

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WILLIE ELIZABETH HARRIS

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7261

07250

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u>				c. LENGTH OF STAY IN 1b <u>82 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>201 S. Mechanic Street</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Annetta</u> Middle <u>Moreland</u> Last <u>Gloss</u>				4. DATE OF DEATH Month <u>June</u> Day <u>6</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 9 1878</u>	9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>27</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Sharpsburg Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>David Gloss</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Hagenberger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Charles F. Gross</u>		201 S. Mechanic St <u>Sharpsburg Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Generalized arteriosclerosis</u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>7 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>home</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>5-31-1961</u> to <u>6-6-1961</u> , that (I) (we) last saw the deceased alive on <u>6-6-1961</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph Secondari</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>6-6-61</u>				
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARI</u>		22d. ADDRESS <u>BOONSBORO Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>June 8-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>	23d. LOCATION (City, town, or county) (State) <u>Sharpsburg Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>			ADDRESS <u>Williamport, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 8 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Albert L. Leaf</u>	

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 10 Hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Md. State Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
f. STREET ADDRESS 412 Brookline Ave				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Carl William Guessford Sr CARL WILLIAM Sr. GUESSFORD				4. DATE OF DEATH Month JUNE Day 26 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 12 1896	
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min.		11. IF UNDER 24 HRS. Months 14 Days 14 Hours 14 Min.		12. IF UNDER 24 HRS. Months 14 Days 14 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver				10b. KIND OF BUSINESS OR INDUSTRY Bester-Long			
11. BIRTHPLACE (State or foreign country) Hagerstown Wash Co Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Robert Lee Guessford				14. MOTHER'S MAIDEN NAME Sarah Everhart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 213-34-8777			
17. INFORMANT Mrs Wilda G. Guessford				Address 412 Brookline Ave Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia DUE TO 141.9 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of Tongue DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH unknown 14 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from 6-26-1961 to 6-26-1961 , that (I) (the hospital) saw the deceased alive on 6-26-1961 , and that death occurred at 11:25 PM , from the causes and on the date stated above.							
22a. SIGNATURE Antonio U. Pallagrosi				22b. DATE SIGNED June 27, 1961			
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLAGROSI				22d. ADDRESS 1500 PENNA AVE HAGERSTOWN MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/29/61			
23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Gardens				23d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				25a. REC'D BY REGISTRAR JUN 29 '61			
ADDRESS Hagerstown Md.				25b. REGISTRAR'S SIGNATURE Charles S. Frank			

CERTIFICATE OF DEATH

1907

(14)

(1)

TO THE VITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

7263

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07252

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural (Hagerstown)</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>R.D.1 Hagerstown</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>C.</u> Last <u>Guessford</u>				4. DATE OF DEATH Month <u>June</u> Day <u>27</u> Year <u>1961</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/4/1896</u>		9. AGE (In years lost birthday) yrs. <u>64</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Potomac Edison Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Welsh Run, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Samuel J. Guessford</u>				14. MOTHER'S MAIDEN NAME <u>Minerva E. Shaffer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-10-3993</u>		17. INFORMANT Address <u>Mrs. Harry W. Carbaugh Smithsburg, Md. R.D.2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u>10 Yrs.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 Days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>Smithsburg, Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>8-28-51</u> 19 <u>51</u> , to <u>6-25-61</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6-25-61</u> 19 <u>61</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Charles F. Hess</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-27-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess, M. D.</u>				22d. ADDRESS <u>Smithsburg, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/30/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Welsh Run Brethern</u>		23d. LOCATION (City, town, or county) (State) <u>Mercersburg Pa. R.D.3 Pa.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Z. Grove</u>				ADDRESS <u>Waynesboro, Pa.</u>		25a. REC'D BY REGISTRAR DATE <u>III 3 '61</u>	
						25b. REGISTRAR'S SIGNATURE <u>Charles E. Huns</u>	

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1965

CERTIFICATE OF BOARD

1965

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7264

07253

1. PLACE OF DEATH COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Martin Manor Nursing Home				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 903 Woodland Way a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES ALLEN HAHN		4. DATE OF DEATH June 12 1961		5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 4 1881		9. AGE (In years last birthday) 79		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Refrigeration Ladiesburg Fred Co		11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James A. Hahn		14. MOTHER'S MAIDEN NAME Augusta Bierley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Mrs Maude Greager Hahn 903 Woodland Way Hagerstown Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) emphysema & congestive failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis genl DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 1 wk years			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 12/19/58 , 19....., to 6/12/61 , 19....., that (I) (we) last saw the deceased alive on 6/6/61 , 19....., and that death occurred at.....M, from the causes and on the date stated above.							
22a. SIGNATURE Howard N. Weeks, M.D.		22b. DATE SIGNED 6/14/61		22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		22d. ADDRESS 136 N. Potomac St. Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/15/61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				25a. REC'D BY REGISTRAR JUN 19 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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Howard H. Weeks, M.D.

138 N. Potomac St., Maryland

Howard H. Weeks, M.D.

CERTIFICATE OF DEATH

Reg. Dist. No. 07254

7265

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 8 hours			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First MATTIE Middle SUSAN Last HARSHMAN				4. DATE OF DEATH Month June Day 9 Year 1961			
5. SEX female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1893	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min.	IF UNDER 24 HRS. Months 68 Days 68 Hours 68 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Cyrus Blickenstaff				14. MOTHER'S MAIDEN NAME Flora Palmer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		INFORMANT Address J. Frank Harshman, Myersville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Coronary Occlusion DUE TO (b) Arteriosclerotic CVD. DUE TO (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 12 Hrs. 5 yrs. 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-15 , 19 56 , to 6-9 , 19 61 , that I last saw the deceased alive on 6-9 , 19 61 , and that death occurred at 7:05 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Charles F. Hess M.D.				ADDRESS (Street, city or town, state) DATE SIGNED Smithsburg Md. 6-10-61			
PHYSICIAN'S NAME (Type) Charles F. Hess							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		June 12, 1961		Grossnickle's		Nr. Myersville, Fred. Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle				ADDRESS Myersville, Md.		24a. REC'D BY REGISTRAR JUN 13 '61	
						24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

Page 4

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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7265

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07255

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)			
a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 1/2 Yrs		d. STREET ADDRESS 1708 Crest Drive	
e. COUNTY MARYLAND		f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ELIZABETH		4. DATE OF DEATH June 17 1961		5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 6 1872		9. AGE (In years last birthday) 88		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>	
11. BIRTHPLACE (County & State, or foreign country) Halifax England		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William H. Hyde		14. MOTHER'S MAIDEN NAME Mary Harris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Ernestine H. Marvin		Address 1708 Crest Drive Hagerstown	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 12 hr 1 yr			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from Feb 1956 to June 17, 1961 , that (I) (the hospital) last saw the deceased alive on Feb 17, 1961 , and that death occurred at 11 A.M. from the causes and on the date stated above.							
22a. SIGNATURE David A. Hoffman				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) DAVID A. HOFFMAN				22d. ADDRESS 214 N. Potomac St. Hagerstown, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/21/61		23c. NAME OF CEMETERY OR CREMATORY Beechwood Cemetery		23d. LOCATION (City, town or county) (State) Ottawa Ontario Canada	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR JUN 20 '61	
						25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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Artistic & Literary Work Division
Mozambique, Interiors

April 1947
George C. Hoffmann
Hoffmann, George C.
214 N. Belmont St.
New York 17, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 17, MARYLAND

7 & CERTIFICATE OF DEATH

7267

Items 9 Film G289

6/10/61 iwk

07256

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland c. LENGTH OF STAY IN 1b 60yrs d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland. d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Samuel Middle Paul Last Hipkins		4. DATE OF DEATH Month June Day 8 Year 19 61	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 22 1890
9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Big Pool Md.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Henry Hipkins		14. MOTHER'S MAIDEN NAME Katherine William	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. T.A. William 313 N. Potomac St.	
17. INFORMANT Address 313 N. Potomac St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma - Esophagus 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis general DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 26 1961 to June 8 1961 , that (I) (we) lost saw the deceased alive on June 8 1961 , and that death occurred at 6:50 AM , from the causes and on the date stated above.			
22a. SIGNATURE Philip J. Hirshman		22b. DATE 6/10/61	
22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		22d. ADDRESS 159 W. Washington St. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-10-1961	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr Hagerstown Md.		25a. REC'D BY REGISTRAR DATE JUN 19 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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DEPARTMENT OF THE ARMY

OFFICE OF THE ADJUTANT GENERAL

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7269

07257

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> 5 weeks c. LENGTH OF STAY IN tb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garlock Memorial Home</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Myersville</u> 10X-2 d. STREET ADDRESS <u>Rt. # 1 Wolfsville</u> a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>ASBURY E. HOOVER</u>				4. DATE OF DEATH <u>June 13 19 61</u>							
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 7, 1876</u>		9. AGE (In years last birthday) <u>85</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own gen farm</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>John Jacob Hoover</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Ann Kline</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>219-36-4449</u>				17. INFORMANT <u>Mrs. Mary J. Hoover, Myersville, Md. Rt. #1</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								INTERVAL BETWEEN ONSET AND DEATH <u>5 Days</u> <u>10 Yrs.</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour _____ s.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-30</u> 19 <u>57</u> to <u>6-13</u> 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>6-12</u> 19 <u>61</u> and that death occurred at <u>10:45 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Charles F. Hess</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-14-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u>						22d. ADDRESS <u>Smithsburg Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>June 16, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Marks Lutheran</u>				23d. LOCATION (City, town or county) <u>Wolfsville, Fred. Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Paul F. Bittle</u>						25a. REC'D BY REGISTRAR <u>DATE JUN 20 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles F. Hess</u>			

TO HOUSING OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

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Charles E. Smith

Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D. C.

Dear Mr. Hoover:

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07253

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Marguerite Hoover				4. DATE OF DEATH Month Day Year June 22 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 28 1899	
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 5 24		11. BIRTHPLACE (State or foreign country) Salisbury Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress				10b. KIND OF BUSINESS OR INDUSTRY Furniture Factory			
13. FATHER'S NAME Dr. Joseph Wiederhold				14. MOTHER'S MAIDEN NAME Louise Heim			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No none				16. SOCIAL SECURITY NO. 216 03 6220			
17. INFORMANT Roy Hoover				Address 2649 Virginia Ave. ext. Williamsport Md. RFD #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of colon 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 6/1 1961 to 6/22 1961, that (I) (we) lost saw the deceased alive on 6/22 1961, and that death occurred at 8:04 A.M. from the causes and on the date stated above.							
22a. SIGNATURE John H. Hornbaker				22b. DATE SIGNED 6-23-61			
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.				22d. ADDRESS 154 West Washington St., Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 26-61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf				25a. REC'D BY REGISTRAR DATE JUN 27 '61			
25b. REGISTRAR'S SIGNATURE Charles S. Kraus							

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **07259**

7270

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 50 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 338 N. Cannon Ave.,				d. STREET ADDRESS 338 N. Cannon Ave.,			
3. NAME OF DECEASED (Type or print) Roy Scott Hoover				4. DATE OF DEATH Month 6 Day 29 Year 19 61			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 7, 1881		9. AGE (In years last birthday) 79 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY self		11. BIRTHPLACE (State or foreign country) Fiddlersburg, Md.	12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Columbus Hoover			14. MOTHER'S MAIDEN NAME Laura Ellen Rohrer				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-05-6827		17. INFORMANT Miss May G. Hoover Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterio Sclerotic Heart Dis.</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) </div> <div style="width: 15%; text-align: center;"> INTERVAL BETWEEN ONSET AND DEATH <i>4 yrs.</i> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>[Signature]</i> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 6/30/61			
EXAMINER'S NAME (Type) W. E. W. J. T. O. J.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 7-3-61		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			
22d. LOCATION (City, town, or county) Hagerstown		(State) Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Kraiss Funeral Home				ADDRESS Hagerstown, Md.			
24a. REC'D BY REGISTRAR JUL 3 '61		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

MEDICAL CERTIFICATION

TO DECEASED: This certificate should be executed within 24 hours after death. If only one is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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7271

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07260

1. PLACE OF DEATH a. COUNTY WASHINGTON		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 1 WEEK		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING, MD.		d. STREET ADDRESS NONE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELSIE PRUDENCE HORNBAKER		First		Middle		Last		4. DATE OF DEATH Month JUNE Day 14 Year 19 61					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 25, 1892		9. AGE (In years lost birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME DUTIES		11. KIND OF BUSINESS OR INDUSTRY HOUSE WORK		12. BIRTHPLACE (State or foreign country) FRANKLIN CO. PA.		13. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME MARTIN DRURY		14. MOTHER'S MAIDEN NAME ELLIE BRITTON											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT WILLIAM L. HORNBAKER, CLSPG. MD.RD.1		Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CALCAREOUS AORTIC STENOSIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RHEUMATIC HEART DISEASE DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Clear Spring, Maryland		(County)		(State)			
21. I certify that (I) (the deceased) attended the deceased from March 28, 1958 to June 14, 1961 , that (I) (we) last saw the deceased alive on June 13, 1961 , and that death occurred at 4:30 AM from the causes and on the date stated above.													
22a. SIGNATURE <i>Archie Robert Cohen</i> M.D.		22b. DATE SIGNED 6/15/61		22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.		22d. ADDRESS Clear Spring, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 17, 1961		23c. NAME OF CEMETERY OR CREMATORY SHANKTOWN CEMETERY		23d. LOCATION (City, town, or county) SHANKTOWN, MD.		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Clark</i>		25a. REC'D BY REGISTRAR DATE JUN 19 61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Howard</i>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7272											
07261											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 1/2 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Martin Manor						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 620 Potomac Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First MOLLIE Middle MIDDLEKAUFF Last HOWARD						4. DATE OF DEATH Month June Day 23 Year 1961					
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 16 1876		9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Hagerstown Wash Co Md.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Middlekauff						14. MOTHER'S MAIDEN NAME Ann Horine					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. None		17. INFORMANT Claytor Howard 1222 Virginia Ave Hagerstown Md. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cervix-Retrograde Infection 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) with Congestive Cardiac Failure DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1946 to 6-23 , 19 61 , that (I) (we) last saw the deceased alive on 6-23 , 19 61 , and that death occurred 6:45 PM , from the causes and on the date stated above.											
22a. SIGNATURE Dalton M. Welty M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dalton M. Welty, M.D.						22d. ADDRESS 998 Potomac Ave., Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/26/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) Hagerstown Wash Co Md. (State)					
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.						25a. REC'D BY REGISTRAR JUN 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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Handwritten signature or text

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
7273 07262											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Clearman Spring</u> c. LENGTH OF STAY IN 1b <u>1 Yr. 11 Mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Gateway Convalescent Home Inc.</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hancock</u> d. STREET ADDRESS <u>Main St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Effie S. Hughes</u>			4. DATE OF DEATH Month <u>6</u> Day <u>3</u> Year <u>19 61</u>		5. SEX <u>Female</u>			6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>Addison, Pennsylvania</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>William Stark</u>					14. MOTHER'S MAIDEN NAME <u>Ella F. Tishue</u>					15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO.					17. INFORMANT <u>Mrs. Margaret Coleman</u>					Address <u>Pittsburg, Penna.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis, Severe</u> DUE TO 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Marked Cerebral Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>Several Years.</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>[Signature]</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>6-5-61</u>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto Jr.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
					Address (Street, city, town, or county)						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>6/7/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Thomas Episcopal</u>			22d. LOCATION (City, town, or country) <u>Hancock Maryland</u>			
23. FUNERAL DIRECTOR <u>Kathleen M. Grose</u>					24a. REC'D BY REGISTRAR <u>Hancock Md.</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

33582

81

12. 11. 0. Hancock
12. 11. 0. Hancock

Female White 1911/1907 73

William Stark
Lillian F. Tamm
Lillian F. Tamm

Mrs. Margaret Olson Peterson, 1911/1907

1911/1907

1911/1907

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7274

07263

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b LIFE			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MD. STATE HOSPITAL				d. STREET ADDRESS 807 SALEM AVE.			
3. NAME OF DECEASED (Type or print) First Ruth Middle Viola Last KENDALL				4. DATE OF DEATH Month 6 Day 3 Year 1961			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV. 3, 1902	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINE OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY AIRCRAFT		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARRY T. MOATS				14. MOTHER'S MAIDEN NAME BESSIE MILLER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 212-14-7431		17. INFORMANT MRS. MAE KOONTZ Address RT 2 GREENCASTLE, PENNA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the lung DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH One week 5 months						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebrovascular accident	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 11, 1961 to June 3, 1961 that (I) was last saw the deceased alive on June 3, 1961 and that death occurred at 3:47 M, from the causes and on the date stated above.							
22a. SIGNATURE Young E. Chun		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED June 3, 1961			
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN		22d. ADDRESS 1500 Penna Ave Hagerstown Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE 6, 1961		23c. NAME OF CEMETERY OR CREMATORY SMITHSBURG		23d. LOCATION (City, town, or county) (State) WASHINGTON COUNTY, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE FRED W. KRAISS				ADDRESS HAGERSTOWN, MD.		25a. REC'D BY REGISTRAR DATE JUN 6 '61	
						25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

1950

CERTIFICATE OF DEATH

774



John W. K. K. K.

Case number of the group: 1000

Case number of the group: 1000

John W. K. K. K.

John W. K. K. K.

John W. K. K. K.

John W. K. K. K.

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07264

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>39</u> years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>233 West Side Ave.</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>233 West Side Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Virginia Captolia Kershner</u>			4. DATE OF DEATH Month <u>June</u> Day <u>22</u> Year <u>1961</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1903</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Chambersburg, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u> </u>			13. FATHER'S NAME <u>Elmer Leidig</u>				
14. MOTHER'S MAIDEN NAME <u>Mary Smeltzar</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> 16. SOCIAL SECURITY NO. <u>----</u>				
17. INFORMANT <u>Paul B. Kershner</u>			Address <u>Hagerstown, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crown Throat Injuries</u> <u>287X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause last. } DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u> </u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTORY <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <u>DOE W. T. T. J.</u>		Address (Street, city, town, or county) <u> </u>		DATE SIGNED <u>6/23/61</u>			
22b. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22c. DATE THEREOF <u>6-25-61</u>	22d. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	22e. LOCATION (City, town, or country) <u>Hagerstown, Md.</u>	(State) <u> </u>			
23. FUNERAL DIRECTOR <u>Scott F. Minnich & Son</u>		ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>JUN 27 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		

M

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MEDICAL CERTIFICATION

FOR STATE
HEALTH DEPT.

(M)

(I)

DATE
TIME

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7276

07265

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
c. LENGTH OF STAY in lb <u>1 week</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>(Rural) Williamsport</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>R. F. D. #4</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ernest Milburn Kirby</u>				4. DATE OF DEATH Month Day Year <u>June 4 19 61</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 18 1905</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days <u>0 16</u>		IF UNDER 24 HRS. Hours Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Water Plant Operator</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Water Works</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Berkeley Co. W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>James William Kirby</u>				14. MOTHER'S MAIDEN NAME <u>Ella Barrow</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>215 01 9972</u>		17. INFORMANT <u>Mrs. Helen E. Kirby</u>	
				Address <u>Williamsport Md.</u> <u>RFD #4</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]							INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma</u>							<u>6 mos</u>
DUE TO (b) <u>Prostatic Carcinoma</u>							<u>18 mos</u>
DUE TO (c) _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
<u>none</u>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) (County) (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>May 6-3 1961</u> to <u>6-4 1961</u>, that (II) (we) last saw the deceased alive on <u>6-3 1961</u>, and that death occurred at <u>2:30 PM</u>, from the causes and on the date stated above.							
22a. SIGNATURE <u>M. E. Byrkit</u>				22b. DATE SIGNED <u>6-5-61</u>		22c. PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>	
22d. ADDRESS <u>Williamsport, Md</u>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <u>Williamsport, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 7-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Williamsport Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williamsport, Md</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

M

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CERTIFICATE OF DEATH

Prostatic Cancer

M.F. B. Kit
M.F. B. Kit

May 28 1900

Williamport, N.H.

Wm. B. Williamsport, N.H.

7277

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07266

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 49 yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 139 N. Potomac St.,				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Frederick Middle William Last Kraiss				4. DATE OF DEATH Month 6 Day 12 Year 61			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 19-1893	
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Funeral Director				10b. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (State or foreign country) Tioga, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Paul Kraiss				14. MOTHER'S MAIDEN NAME Helen Harer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 219-36-2711		17. INFORMANT Address Mrs. Margaret Kraiss Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO arterio-sclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 6-12-61							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 4-1-61 19 to 6-12-61 19, that (I) (we) last saw the deceased alive on 6-12-61 19, and that death occurred at PM , from the causes and on the date stated above.							
22a. SIGNATURE H. E. W. J. T. T. O. J. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) H. E. W. J. T. T. O. J. 22d. ADDRESS Hagerstown Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 6-15-61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Kraiss Funeral Home Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE JUN 16 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraiss	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1935

CERTIFICATE OF DEATH

Attest: _____
Registrar

Date

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

Signature

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07267

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b 28 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 656 Virginia Ave.				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 1 656 Virginia Ave.			
3. NAME OF DECEASED (Type or print) First JOHN Middle MELCAJAH Last LACY, JR.				4. DATE OF DEATH Month June Day 22 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 30, 1907	
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 0 Days 0		IF UNDER 24 HRS. Hours 0 Min. 0		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager				10b. KIND OF BUSINESS OR INDUSTRY shoe store		11. BIRTHPLACE (County & State, or foreign country) Scottsburg, Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John M. Lacy, Sr.				14. MOTHER'S MAIDEN NAME Emaline Priest			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W.W. II 214-09-C372		17. INFORMANT Mrs. Ruth Lacy	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 202.1 metastatic lymphoma Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 202.1 DUE TO (b) 202.1 DUE TO (c) 202.1				INTERVAL BETWEEN ONSET AND DEATH 3 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/11/1958 , to 6/22/1961 , that (I) (we) last saw the deceased alive on 6/21/1961 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE Robert V. H. Campbell M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/22/61	
22c. PHYSICIAN'S NAME (Type) Robert V. H. Campbell				22d. ADDRESS Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/24/1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home R. Franklin Berger				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR JUN 28 '61	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kneass			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

Washington

Washington

28 years

Washington

616 Virginia Ave.

616 Virginia Ave.

JOHN

WILLIAM

JOHN

JOHN

JOHN

White

November 30, 1907

London

John

Washington, D.C.

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United States

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

7279
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07268

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown Md.				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Maryland			
c. LENGTH OF STAY IN lb 1 Mo. 5 Days				d. STREET ADDRESS Gate Way Nursing Home			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Aaron Middle Henderson Last Lanehart				4. DATE OF DEATH Month 6 Day 26 Year 1961			
5. SEX M		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 20, 1878	
9. AGE (In years last birthday) 83		10. IF UNDER 1 YEAR Months 6 Days 26 Hours 19 Min. 61		11. BIRTHPLACE (State or foreign country) Fulton County Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor				10b. KIND OF BUSINESS OR INDUSTRY Saw Mill			
13. FATHER'S NAME Issac Lanehart				14. MOTHER'S MAIDEN NAME Savannah Younker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 204.01.5368			
17. INFORMANT Preston E Lanehart				Address Hagerstown Md. 2001 Lexington Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Valvular Disease DUE TO (c) Sudden INTERVAL BETWEEN ONSET AND DEATH 3 yrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Clear Spring Md.				20g. (County) Hancock		20h. (State) Md.	
21. I certify that (I) (this hospital) attended the deceased from May 20, 1961 to June 26, 1961 , that (I) (we) last saw the deceased alive on June 26, 1961 , and that death occurred at 5:30 P.M. from the causes and on the date stated above.							
22a. SIGNATURE David R. Brewer				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/27/61	
22c. PHYSICIAN'S NAME (Type) David R. Brewer				22d. ADDRESS Clear Spring Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6.29.61		23c. NAME OF CEMETERY OR CREMATOR Park Head	
23d. LOCATION (City, town, or county) Rural Hancock Washington Md				23e. (State) Md.		23f. (Country) U.S.A.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard J. Hume				ADDRESS Hancock Md		25a. REC'D BY REGISTRAR DATE JUN 29 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hume							

1958

DEPARTMENT OF HEALTH

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Washington

Washington

Washington

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07269

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Pa. b. COUNTY Franklin c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willow Hill, Pa. d. STREET ADDRESS 75X-3	
3. NAME OF DECEASED (Type or print) Mary E. Lehman		4. DATE OF DEATH Month June Day 28 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18 1902
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Maugansville Wash. Co. Md.	
13. FATHER'S NAME David Martin		14. MOTHER'S MAIDEN NAME Mary Horst	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. none	
17. INFORMANT Howard F. Lehman		Address Willow Hill, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction? 420.0 DUE TO (b) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arterial Sclerosis.		INTERVAL BETWEEN ONSET AND DEATH 1 day	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 27 JUNE , 19 61 , to 28 JUNE , 19 61 , that (I) (we) last saw the deceased alive on 27 JUNE , 19 61 , and that death occurred atM. from the causes and on the date stated above.			
22a. SIGNATURE Richard T. Binford M.D.		22b. DATE SIGNED 30 June 61	
22c. PHYSICIAN'S NAME (Type) Richard Binford M.D.		22d. ADDRESS 1135 POTOMAC AVENUE, HAGERSTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/1/1960	23c. NAME OF CEMETERY OR CREMATORY Chambersburg Mennonite Chambersburg, Pa.	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR'S SIGNATURE Chas. M. Rouser - For		25a. REC'D BY REGISTRAR Chambersburg, Pa.	
25b. REGISTRAR'S SIGNATURE Shelley Ann Home Chambersburg Pa.		25c. DATE JUL 3 '61	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(1)

Washington

Washington

Washington County Hospital

Washington

Washington

David Harris

Edward E. Harris

Ellen Hill

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07270

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland f. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown (Rural) g. STREET ADDRESS Avalon Manor h. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GRACE Middle CANNON Last LOOSE		4. DATE OF DEATH Month June Day 7 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 27, 1879
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days 	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY Hagerstown, Md.	
11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Clay Loose		14. MOTHER'S MAIDEN NAME Virginia Pearson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Victor D. Miller		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Pancreatitis 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO cause last. (c) 			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Hypertensive vascular disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (as hospital) attended the deceased from June 1, 1961 to June 7, 1961 , that (I) (we) last saw the deceased alive on June 7, 1961 , and that death occurred at 10 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Lloyd A. Hoffman M.D.		22b. DATE SIGNED 6/8/61	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		22d. ADDRESS 214 N. Potomac St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/9/1961	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home		25a. REC'D BY REGISTRAR Arthur S. Kraus	
25b. REGISTRAR'S SIGNATURE Hagerstown, Md.		DATE JUN 12 '61	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

Washington

Washington

Legation

Legation (Paris)

San Antonio General Hospital

Aviation Bureau

Legation - White

June

Honorable

Honorable

Henry Clay House

Virginia House

Mr. Victor W. Miller, Washington, D.C.

~~Mr. Victor W. Miller, Washington, D.C.~~

X

Rose Hill Cemetery

Legation

Legation

Super - General Hospital

Washington, D.C.

June 2, 1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Item 6 Film G290 7/3/61 iwk

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 5 Hagerstown Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Chronic Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>Thomas</u> Last <u>MACCUMBEE</u>		4. DATE OF DEATH Month <u>6</u> Day <u>23</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 5, 1948</u>
9. AGE (In years last birthday) <u>13</u> yrs.		10. IF UNDER 1 YEAR Months <u>13</u> Days <u>23</u> Hours <u>16</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Student</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Vernon E MacCumbsee</u>		14. MOTHER'S MAIDEN NAME <u>Vergie M Van Gosen</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Vernon E MacCumbsee</u>		Address <u>Rural 5 Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lobular Pneumonia</u> DUE TO <u>196-9</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ewing's Sarcoma with Metastasis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>one week</u> <u>6 months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>one week</u> <u>6 months</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 20, 1961</u> , to <u>June 23, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 23, 1961</u> , and that death occurred at <u>7:55 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Young E. Chun</u>		22b. DATE <u>June 23, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>		22d. ADDRESS <u>1500 Penna. Ave. Hagerstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6.26.61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters Catholic</u>		23d. LOCATION (City, town, or county) (State) <u>Hancock Washington Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard F. Stone</u>		25a. REC'D BY REGISTRAR <u>Hancock Md</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>		DATE <u>JUN 28 '61</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

7283

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 07272

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Route # 4 Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>16 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Route # 4 Hagerstown</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Route # 4</u>				d. STREET ADDRESS <u>Route # 4</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Homer</u> Middle <u>Oliver</u> Last <u>Marquiss</u>				4. DATE OF DEATH Month <u>June</u> Day <u>23</u> Year <u>19 61</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 27, 1894</u>		
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>		11. BIRTHPLACE (State or foreign country) <u>Pine County, Ill.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Oliver Abraska Marquiss</u>				14. MOTHER'S MAIDEN NAME <u>Sadie E. White</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>351-07-0528</u>		17. INFORMANT <u>E. E. Marquiss</u>		Address <u>Hagerstown, Maryland</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>191-3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma Involving The Right Temporal &</u> DUE TO <u>Maxillary Area Of Face.</u> (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 minutes</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>E. W. Ditto Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>E. W. Ditto Jr.</u> M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>6/26/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. C. Horst</u>				24a. REC'D BY REGISTRAR <u>JUN 23 '61</u>		24b. REGISTRAR'S SIGNATURE <u> </u>		

M

I

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7284

07273

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville, md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. Co. Hospital</u>				d. STREET ADDRESS <u>Maugansville, md</u>			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>NATHAN</u> Middle <u>S.</u> Last <u>MARTIN</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/5/1915</u>		9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POULTRY FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wash. Co, md.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel MARTIN</u>				14. MOTHER'S MAIDEN NAME <u>Rebecca Shank</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-12-0709</u>		17. INFORMANT <u>Mrs. Bertha Martin</u>		Address <u>Maugansville md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 days -</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/28, 1961</u> to <u>6/3, 1961</u> , that (I) (we) last saw the deceased alive on <u>6/3 1961</u> , and that death occurred <u>5 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John H Hornbaker</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6-5-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>John H. Hornbaker, M.D.</u>				22d. ADDRESS <u>154 West Washington St., Hagerstown, Md.</u>			
23a. BURIAL OR CREMATION, REMOVAL (Specify) <u>B</u>		23b. DATE THEREOF <u>6/6/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Reiff Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Clearfoss, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>D.E. Minnich</u>				24a. REC'D BY REGISTRAR <u>Greencastle Pa.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiana</u>	
				25a. DATE <u>JUN 8 '61</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

(M)

1. The following information was received from the
1st Battalion, 1st Infantry Division, on 10/10/54.
The 1st Battalion, 1st Infantry Division, is currently
located at the 1st Infantry Division, 1st Infantry
Division, 1st Infantry Division, 1st Infantry Division.
The 1st Battalion, 1st Infantry Division, is currently
located at the 1st Infantry Division, 1st Infantry
Division, 1st Infantry Division, 1st Infantry Division.
The 1st Battalion, 1st Infantry Division, is currently
located at the 1st Infantry Division, 1st Infantry
Division, 1st Infantry Division, 1st Infantry Division.

CHIEF OF BATTALION

2. The following information was received from the
1st Battalion, 1st Infantry Division, on 10/10/54.
The 1st Battalion, 1st Infantry Division, is currently
located at the 1st Infantry Division, 1st Infantry
Division, 1st Infantry Division, 1st Infantry Division.
The 1st Battalion, 1st Infantry Division, is currently
located at the 1st Infantry Division, 1st Infantry
Division, 1st Infantry Division, 1st Infantry Division.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MAYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7285

07274

1. PLACE OF DEATH e. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 19 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 111 North Locust Street				d. STREET ADDRESS 111 North Locust Street		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) WILLIAM FERMAN McBRIDE				4. DATE OF DEATH Month June Day 2 Year 1961			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 27, 1876		9. AGE (In years last birthday) 84 yrs.	IF UNDER 24 HRS. Months 2 Days 2 Hours 1961	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor W.M.R.R. Railroad			10b. KIND OF BUSINESS OR INDUSTRY Western Maryland Mineral Co. W.Va. Patterson Creek,			12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Colum McBride				14. MOTHER'S MAIDEN NAME Mary V. Ullum			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-10-7249		17. INFORMANT Ira W. McBride Address Cumberland, Maryland 437 Goethe St.			
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420.0 DUE TO Coronary Occluding infarction Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) Arteriosclerotic heart disease (c) 3 Day + years						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Intestinal obstruction probable. Bundle branch block.							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9 July 52 to 2 June 61 , that (I) (we) last saw the deceased alive on 1 June 61 , and that death occurred at 9:00 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE Richard T. Binford				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2 JUNE, 1961	
22c. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D.				22d. ADDRESS 1135 POTOMAC AVENUE, HAGERSTOWN, MO.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/4/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Wash. Co. Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown, Maryland		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JUN 7 '61 Arthur L. Kraus	

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Carson's Building & Repairing
Establishment, 1000 Broadway, N.Y.

X Attention: Mr. Carson. Please send me

1 June 61
Richard T. Gifford
X
2 July 61
at 5 June 61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7286

07275

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 17 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Katherine Louise Mentzer				4. DATE OF DEATH Month Day Year June 21 19 61			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1913		9. AGE (In years lost birthday) yrs. 47	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Planner		10b. KIND OF BUSINESS OR INDUSTRY Aircraft		11. BIRTHPLACE (State or foreign country) Lovettsville, Va.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Franklin P. Mentzer				14. MOTHER'S MAIDEN NAME Ida Grams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-20-9013		17. INFORMANT Address Miss Virgie E. Mentzer Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain Abscess 342X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) Diabetes Mellitus. Arteriosclerotic and Hypertensive Cardiovascular Disease. Intracapillary glomerulonephritis.							INTERVAL BETWEEN ONSET AND DEATH Indeterminate.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from June 7 19 61 to June 21 19 61 , that (I) (he) last saw the deceased alive on June 21 19 61 , and that death occurred at 11:35a from the causes and on the date stated above.							
22a. SIGNATURE <i>W. T. Layman, M.D.</i>				22b. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland		22c. PHYSICIAN'S NAME (Type) W. T. Layman, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-24-61		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City, town, or county) (State) Lovettsville, Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				25a. REC'D BY REGISTRAR JUN 26 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	

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STATEMENT OF WORK

1. The purpose of this statement is to define the work to be performed by the contractor under the contract.

2. The work shall be performed in accordance with the specifications and drawings attached hereto.

3. The contractor shall be responsible for obtaining all necessary permits and licenses for the performance of the work.

4. The contractor shall maintain accurate records of all work performed and materials used.

5. The contractor shall submit progress reports to the owner at the intervals specified in the contract.

6. The contractor shall be responsible for the safety of all personnel and equipment on the job site.

7. The contractor shall be responsible for the cleanup of the job site after completion of the work.

8. The contractor shall be responsible for the payment of all taxes and fees associated with the work.

9. The contractor shall be responsible for the maintenance of all equipment and tools used in the work.

10. The contractor shall be responsible for the training and supervision of all personnel performing the work.

11. The contractor shall be responsible for the procurement of all materials and supplies needed for the work.

12. The contractor shall be responsible for the coordination of all work with other contractors and agencies involved in the project.

13. The contractor shall be responsible for the completion of the work within the specified time frame.

14. The contractor shall be responsible for the delivery of the work to the owner in accordance with the contract.

15. The contractor shall be responsible for the protection of all existing structures and utilities on the job site.

16. The contractor shall be responsible for the preservation of all natural resources and the environment.

17. The contractor shall be responsible for the implementation of all safety and health measures required by law.

18. The contractor shall be responsible for the maintenance of all records and documents related to the work.

19. The contractor shall be responsible for the payment of all bills and invoices related to the work.

20. The contractor shall be responsible for the overall management and coordination of the work.

1 FOR STATE HEALTH DEPT.

TO DISTRICT MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 7287 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07276

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.		b. COUNTY Wash.	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Funkstown		c. LENGTH OF STAY IN 1b 3 1/2 months		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Funkstown	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Carrie Eva Miller		4. DATE OF DEATH Month June 4,		Day 19	
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH June 11, 1909		9. AGE (In years, last birthday) 51		IF UNDER 1 YEAR Months 51	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic		10b. KIND OF BUSINESS OR INDUSTRY house work		11. BIRTHPLACE (State or foreign country) Smithsburg, Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Albert Reynolds		14. MOTHER'S MAIDEN NAME Lula Kendall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Elmore Miller, Funkstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. DUE TO (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Recent		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE A. S. Smith		M.D. Dr. E. J. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. J. Ditto, Jr.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 6-6-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 6-7-61		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
22d. LOCATION (City, town, or country) Hagerstown, Md.		23. FUNERAL DIRECTOR Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE JUN 8 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

MEDICAL CERTIFICATION

FOR STATE
CLERK

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[Handwritten signature]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

7290

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07273

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 42 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Clyde Francis Moats		4. DATE OF DEATH June 4 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1890
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Paper Hanger		10b. KIND OF BUSINESS OR INDUSTRY wall paper	
11. BIRTHPLACE (State or foreign country) Tilghmanton, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Samuel Moats		14. MOTHER'S MAIDEN NAME Anne Munson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. --	
17. INFORMANT Arthur M. Moats		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Anemia due to hydrophobia DUE TO (b) Cancer of Prostate DUE TO (c) Hypertensive Cardiac-vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH May 5 - 1961	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arterio-sclerosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 5 1961 to June 4 1961 , that (I) last saw the deceased alive on June 4 1961 , and that death occurred at 3:55a M., from the causes and on the date stated above.			
22a. SIGNATURE Sidney Novenstein		22b. DATE SIGNED 6-5-61	
22c. PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN		22d. ADDRESS FUNKSTOWN MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6-6-61	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25a. REC'D BY REGISTRAR JUN 8 '61	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

(M)

(I)

Handwritten notes and signatures, including the name "G. B. Smith" and other illegible text.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7291

CERTIFICATE OF DEATH

Reg. Dist. No.

07280

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE PA. b. COUNTY FRANKLIN			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WAYNESBORO			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 247 PHILADELPHIA AVE.			
3. NAME OF DECEASED (Type or print) GARDNER HOWELL MOATS				4. DATE OF DEATH Month JUNE Day 7 Year 19 61			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEB. 20, 1915	
9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman Maintenance				10b. KIND OF BUSINESS OR INDUSTRY LANDIS MACH. CO.		11. BIRTHPLACE (State or foreign country) Tilghmanton, Md.	
12. CITIZEN OF WHAT COUNTRY? US							
13. FATHER'S NAME J. Leslie Moats				14. MOTHER'S MAIDEN NAME Mary Lambert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 217-10-3118		17. INFORMANT Mrs. Mabel Moats, Waynesboro Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS 483X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) THROMBO PHLEBITIS LEFT LEG DUE TO (c) _____				INTERVAL BETWEEN ONSET AND DEATH 5 MINUTES ONE WEEK			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bronchogenic carcinoma, disseminated, lungs, bilateral.				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from JUNE 7 , 19 61 , to JUNE 7 , 19 61 , that I last saw the deceased alive on JUNE 7 , 19 61 , and that death occurred at 9:10PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 131 W. WASHINGTON ST., HAGERSTOWN, MD DATE SIGNED JUNE 7, 61							
ACTUAL SIGNATURE John H. Kehne M.D.							
PHYSICIAN'S NAME (Type) JOHN H. KEHNE M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 6/10/61		22c. NAME OF CEMETERY OR CREMATORY Green Hill		22d. LOCATION (City, town, or county) (State) Waynesboro, Franklin Co., Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Y. Grove, Waynesboro Pa				24a. REC'D BY REGISTRAR DATE JUN 9 1961		24b. REGISTRAR'S SIGNATURE Charles S. Hume	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 07281

7292

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD.</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> 03			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. COUNTY HOSPITAL</u>				d. STREET ADDRESS <u>205 S. MONT VALLA AVE.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>KIMBERLY LYNN MURRAY</u>				4. DATE OF DEATH Month Day Year <u>JUNE 11 1961</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 11 1961</u>	9. AGE (In years last birthday) yrs. <u>55</u>	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WAYSON ANDREW MURRAY</u>				14. MOTHER'S MAIDEN NAME <u>ELENOBA MAE GROVES</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MOTHER</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>atelectasis</u> 762.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Immaturity</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)		(State)
21. I certify that I attended the deceased from <u>June 11, 1961</u> , to <u>June 11, 1961</u> , that I last saw the deceased alive on <u>June 11, 1961</u> , and that death occurred at <u>2:45 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>F. J. Done Jr.</u> M.D.							
PHYSICIAN'S NAME (Type) <u>DR. F. D. DOVE, JR.</u> <u>HAGERSTOWN, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>6/12/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>W.C.H.</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. B. Turner, W.D.</u> ADDRESS <u>Wash County Hosp.</u>			24a. REC'D BY REGISTRAR DATE <u>JUN 15 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Ernest S. Hume</u>		

2581262XVO

This is to certify that the above named person is dead and that the death has been caused by the disease or injury specified in the certificate of death.
 I, the undersigned, being a duly qualified medical practitioner, hereby certify that the above named person is dead and that the death has been caused by the disease or injury specified in the certificate of death.
 I, the undersigned, being a duly qualified medical practitioner, hereby certify that the above named person is dead and that the death has been caused by the disease or injury specified in the certificate of death.

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CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

1. Name of deceased JAMES M. JONES		2. Sex Male	
3. Date of birth 10-15-1890		4. Place of birth Baltimore, Md.	
5. Date of death 10-22-1962		6. Place of death Baltimore, Md.	
7. Cause of death Myocardial infarction		8. Immediate cause of death Myocardial infarction	
9. Underlying cause of death Myocardial infarction		10. Contributing causes of death Hypertension, Atherosclerosis	
11. Date of death 10-22-1962		12. Time of death 10:00 AM	
13. Signature of attending physician J. Edgar Hoover		14. Signature of medical examiner J. Edgar Hoover	
15. Signature of registrar J. Edgar Hoover		16. Signature of coroner J. Edgar Hoover	
17. Date of registration 10-22-1962		18. Time of registration 10:00 AM	
19. Signature of registrar J. Edgar Hoover		20. Signature of coroner J. Edgar Hoover	
21. Signature of registrar J. Edgar Hoover		22. Signature of coroner J. Edgar Hoover	
23. Signature of registrar J. Edgar Hoover		24. Signature of coroner J. Edgar Hoover	
25. Signature of registrar J. Edgar Hoover		26. Signature of coroner J. Edgar Hoover	
27. Signature of registrar J. Edgar Hoover		28. Signature of coroner J. Edgar Hoover	
29. Signature of registrar J. Edgar Hoover		30. Signature of coroner J. Edgar Hoover	
31. Signature of registrar J. Edgar Hoover		32. Signature of coroner J. Edgar Hoover	
33. Signature of registrar J. Edgar Hoover		34. Signature of coroner J. Edgar Hoover	
35. Signature of registrar J. Edgar Hoover		36. Signature of coroner J. Edgar Hoover	
37. Signature of registrar J. Edgar Hoover		38. Signature of coroner J. Edgar Hoover	
39. Signature of registrar J. Edgar Hoover		40. Signature of coroner J. Edgar Hoover	
41. Signature of registrar J. Edgar Hoover		42. Signature of coroner J. Edgar Hoover	
43. Signature of registrar J. Edgar Hoover		44. Signature of coroner J. Edgar Hoover	
45. Signature of registrar J. Edgar Hoover		46. Signature of coroner J. Edgar Hoover	
47. Signature of registrar J. Edgar Hoover		48. Signature of coroner J. Edgar Hoover	
49. Signature of registrar J. Edgar Hoover		50. Signature of coroner J. Edgar Hoover	
51. Signature of registrar J. Edgar Hoover		52. Signature of coroner J. Edgar Hoover	
53. Signature of registrar J. Edgar Hoover		54. Signature of coroner J. Edgar Hoover	
55. Signature of registrar J. Edgar Hoover		56. Signature of coroner J. Edgar Hoover	
57. Signature of registrar J. Edgar Hoover		58. Signature of coroner J. Edgar Hoover	
59. Signature of registrar J. Edgar Hoover		60. Signature of coroner J. Edgar Hoover	
61. Signature of registrar J. Edgar Hoover		62. Signature of coroner J. Edgar Hoover	
63. Signature of registrar J. Edgar Hoover		64. Signature of coroner J. Edgar Hoover	
65. Signature of registrar J. Edgar Hoover		66. Signature of coroner J. Edgar Hoover	
67. Signature of registrar J. Edgar Hoover		68. Signature of coroner J. Edgar Hoover	
69. Signature of registrar J. Edgar Hoover		70. Signature of coroner J. Edgar Hoover	
71. Signature of registrar J. Edgar Hoover		72. Signature of coroner J. Edgar Hoover	
73. Signature of registrar J. Edgar Hoover		74. Signature of coroner J. Edgar Hoover	
75. Signature of registrar J. Edgar Hoover		76. Signature of coroner J. Edgar Hoover	
77. Signature of registrar J. Edgar Hoover		78. Signature of coroner J. Edgar Hoover	
79. Signature of registrar J. Edgar Hoover		80. Signature of coroner J. Edgar Hoover	
81. Signature of registrar J. Edgar Hoover		82. Signature of coroner J. Edgar Hoover	
83. Signature of registrar J. Edgar Hoover		84. Signature of coroner J. Edgar Hoover	
85. Signature of registrar J. Edgar Hoover		86. Signature of coroner J. Edgar Hoover	
87. Signature of registrar J. Edgar Hoover		88. Signature of coroner J. Edgar Hoover	
89. Signature of registrar J. Edgar Hoover		90. Signature of coroner J. Edgar Hoover	
91. Signature of registrar J. Edgar Hoover		92. Signature of coroner J. Edgar Hoover	
93. Signature of registrar J. Edgar Hoover		94. Signature of coroner J. Edgar Hoover	
95. Signature of registrar J. Edgar Hoover		96. Signature of coroner J. Edgar Hoover	
97. Signature of registrar J. Edgar Hoover		98. Signature of coroner J. Edgar Hoover	
99. Signature of registrar J. Edgar Hoover		100. Signature of coroner J. Edgar Hoover	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/59

7293

7293

CERTIFICATE OF DEATH

07282

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 3 Mos d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Western Maryland State Hospital		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Springs e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John William MYERS		4. DATE OF DEATH Month 6 Day 5 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 22, 1899
9. AGE (In years lost birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 6 Days 4 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Continental Baking Co.	
11. BIRTHPLACE (State or foreign country) Shepherdstown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Myers		14. MOTHER'S MAIDEN NAME Anna Coe Brotherton	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 578-09-6641	
17. INFORMANT Mrs. Margaret A. Myers		Address 8648 Piney Branch Rd., Silver Springs, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBULAR pneumonia, bilateral 161X DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) carcinoma of Larynx & carcinomatosis DUE TO (c) 4 1/2 years		INTERVAL BETWEEN ONSET AND DEATH 4 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 24, 1961 to June 5, 1961 , that (I) met last saw the deceased alive on June 5, 1961 , and that death occurred at 4:10 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Victor L. Ramos		22b. DATE SIGNED JUNE 5, 1961	
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS, M.D.		22d. ADDRESS Western Md. State Hospital Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/7/61	
23c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery		23d. LOCATION (City, town, or county) (State) Shepherdstown, Jefferson City	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JUN 8 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. REGISTRAR'S NAME Arthur S. Kraus	

1953

11

NAME: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
MARRIAGE: [illegible]

DECEASED: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF DEATH: [illegible]

PLACE OF DEATH: [illegible]

SEX: [illegible]

RACE: [illegible]

EDUCATION: [illegible]

OCCUPATION: [illegible]

RELIGION: [illegible]

PREVIOUS MARRIAGES: [illegible]

REMARKS: [illegible]

SIGNATURE OF REGISTRAR: [illegible]

DATE OF ENTRY: [illegible]

FILE NO.: [illegible]

REMARKS: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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7294

MARYLAND STATE BOARD OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07283

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>CANADA</u> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give nearest town) <u>Rural Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>STOUFFVILLE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HAGERSTOWN RD # 5</u>		d. STREET ADDRESS <u>— 90X-3</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DAVID NICHSWANDER</u>		4. DATE OF DEATH Month Day Year <u>June 14 1961</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 23 1886</u>
9. AGE (in years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Work</u>	
11. BIRTHPLACE (State or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>Canada</u>	
13. FATHER'S NAME <u>Enos Nighswander</u>		14. MOTHER'S MAIDEN NAME <u>Elsie Burkholder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mrs Nancy Nighswander</u>		Address <u>Stouffville Canada</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) <u>Arteriosclerotic heart disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>30 min.</u> <u>Indefinite</u> <u>Indefinite</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 14 1961</u> to <u>June 14 1961</u> that (I) (we) last saw the deceased alive on <u>Dead on arrival</u> , and that death occurred <u>at 5 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>B. B. Kneisley</u>		22b. DATE SIGNED <u>6/15/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>		22d. ADDRESS <u>148 West Washington Street Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>		23b. DATE THEREOF <u>6/18/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Stouffville, Canada</u>		23d. LOCATION (City, town or county) (State) <u>Stouffville, Canada.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Minnich</u>		25. REC'D BY REGISTRAR DATE <u>JUN 16 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

1921

(M)

1. Name of deceased
2. Sex
3. Age
4. Date of birth
5. Place of birth
6. Date of death
7. Place of death
8. Cause of death
9. Signature of physician
10. Signature of registrar
11. Date of registration

(T)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

7295

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07284

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write <u>Williamsport</u>) c. LENGTH OF STAY IN 1b <u>1 week</u> d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Downsville Pike</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write <u>Williamsport</u>) d. STREET ADDRESS <u>Downsville Pike</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Clarence</u> Middle <u>Russell</u> Last <u>Norris</u>		4. DATE OF DEATH Month <u>June</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 5 1906</u>
9. AGE (In years last birthday) <u>54</u> yrs.		10. UNDER 1 YEAR Months <u>11</u> Days <u>14</u>	11. UNDER 24 HRS. Hours <u>14</u> Min. <u>14</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Weaverton Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>		13. FATHER'S NAME <u>William A Norris</u>	
14. MOTHER'S MAIDEN NAME <u>Myrtle E. Rowe</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>705 12 5649</u>		17. INFORMANT <u>Mr. Fred Paxton</u> Address <u>404 York Place</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Ch. Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Immediate</u> DUE TO (c) <u>Interval between onset and death</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>6/19/61</u> to <u>6/19/61</u> 19 <u>61</u> , that (I) (we) lost saw the deceased alive on <u>6/19/61</u> and that death occurred <u>at 7 M</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Robert L. Young</u>		22b. DATE <u>6/19/61</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 22-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Boonsboro Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Boonsboro Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u> ADDRESS <u>Williamsport, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 22 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>William S. Thomas</u>			

(M)

1935

CERTIFICATE OF DEATH

1935

State of New York

County of New York

City of New York

On this day of the year 1935

at the City of New York

I, the undersigned, a duly qualified and licensed

Physician, do hereby certify that

the within and foregoing is a true and correct

statement of the facts and circumstances

surrounding the death of the

person named herein, and that the

cause of death was

as stated in the foregoing

statement, and that the

death was not caused by

any of the causes mentioned

in the foregoing statement

as being excluded causes

of death, and that the

death was caused by

the causes mentioned in the

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7296

07285

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 1 1/2 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) 1620 DUAL HIGHWAY		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) STEWART CLARK PAXTON SR.		4. DATE OF DEATH JUNE 18 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/26/1865
9. AGE (In years lost birthday) 95 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PATTERN MAKER MACHINERY MFG.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSIAH PAXTON		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. STEWART C. PAXTON JR.		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Regeneration (c) Arteriosclerosis, general		INTERVAL BETWEEN ONSET AND DEATH 1 hour 1 yr. years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6-18 1961 to 6-18 61 , that (I) (we) last saw the deceased alive on 6-18 1961 and that death occurred at 9P M, from the causes and on the date stated above.			
22a. SIGNATURE D. J. Boyer, M.D.		22b. DATE SIGNED 6-19-61	
22c. PHYSICIAN'S NAME (Type) D. J. Boyer, M.D.		22d. ADDRESS 135 N. Potomac Street Hagerstown, Maryland	
23a. BURIAL, CREMATION, REINTERMENT (Specify) BURIAL		23b. DATE THEREOF 6/20/61	
23c. NAME OF CEMETERY OR CREMATORY ELK VIEW CEM.		23d. LOCATION (City, town, or county) (State) CLARKSBURG W. VA.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant		25a. REC'D BY REGISTRAR DATE JUN 21 '61	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

100

CERTIFICATE OF DEATH

14

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DEPARTMENT OF HEALTH

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TO DUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Form Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

1. PLACE OF DEATH				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)			
a. COUNTY				a. STATE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				b. COUNTY			
c. LENGTH OF STAY IN TB				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
Washington				Maryland			
Hagerstown				Hancock			
Washington County Hospital				Pennsylvania Ave.			
First Middle Last				Month Day Year			
Harry Lowe Powers, Sr.				June 3 1961			
5. SEX				6. COLOR OR RACE			
Male				White			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				8. DATE OF BIRTH			
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				Feb. 21, 1872			
9. AGE (In years last birthday)				89 yrs.			
IF UNDER 1 YEAR				IF UNDER 24 HRS.			
Months Days				Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY			
Penna Sand & Glass Corp.				Wash. Co., Maryland			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John L. Powers				Elizabeth Cooke			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.			
No				None			
17. INFORMANT				Address			
Ida Hull Powers				Pennsylvania Ave. Hancock, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:				6 hours			
IMMEDIATE CAUSE (a)				Fat embolism			
903.0				DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b)			
Fracture of right hip				DUE TO			
(c)				6 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED?			
Patient has been confused due to his age				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
Patient fell on porch at his home							
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED			
Hour m.m. p.m. May 28, 1961				While Not While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
Home				Hancock Wash. Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
Howard J. Hume				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify)				22b. DATE THEREOF			
Burial				6/6/61			
22c. NAME OF CEMETERY OR CREMATORY				22d. LOCATION (City, town, or county) (State)			
St. Pauls Cemetery				Washington Co. Maryland			
23. FUNERAL DIRECTOR				24a. REC'D BY REGISTRAR			
Howard J. Hume				24b. REGISTRAR'S SIGNATURE			
Hancock Md.				DATE JUN 9 '61			

081

1

DATE SIGNED
6/6/61



DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S OFFICE
1911

John L. Jones

John L. Jones

John L. Jones

John L. Jones

John L. Jones

John L. Jones

1

7299

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07288

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>10 Weeks</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pectonville</u> d. STREET ADDRESS <u>Pectonville</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>Walter</u> Last <u>Reed</u>			4. DATE OF DEATH Month <u>6</u> Day <u>2</u> Year <u>1961</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/22/1899</u>	9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>2</u> Hours <u>1</u> Min. <u>1</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trackman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>W. Md. R R</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			13. FATHER'S NAME <u>Jeremiah Reed</u>				
14. MOTHER'S MAIDEN NAME <u>Emma Bloyer</u>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				
16. SOCIAL SECURITY NO. <u>705-10-7933</u>			17. INFORMANT <u>Elsie May Reed</u> Address <u>Hancock Route #3</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GENERALIZED Abdominal Carcinomatosis</u> <u>153.3</u> DUE TO <u>CARCINOMA OF Sigmoid Colon</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>1 yr.</u> (c) <u>1 yr.</u>					INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>19. WAS AUTOPSY PERFORMED?</u> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Dec. 1, 1960</u> to <u>June 2, 1961</u> , that (I) <u>(last)</u> saw the deceased alive on <u>Jun 2, 1961</u> , and that death occurred at <u>4P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>John A. Moran</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>JOHN A. MORAN.</u>		22d. ADDRESS <u>215 W. WASHINGTON ST., HAGERSTOWN.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6/5/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Orchard Ridge Church</u>	23d. LOCATION (City, town, or county) (State) <u>Washington Maryland</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Hare</u>		ADDRESS <u>Hagerstown Md</u>		25a. REC'D BY REGISTRAR <u>JUN 6 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

M

1997

CERTIFICATE OF DEATH

1997

John A. Moran
1918-1997
Born 11-11-1918
Died 11-11-1997
Cause of Death
Age 79
Buried in
John A. Moran
1918-1997
Born 11-11-1918
Died 11-11-1997
Cause of Death
Age 79
Buried in

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
7300		Item 8 Film 0209 6/25/61 iwk				07289			
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Mapleville			c. LENGTH OF STAY IN 1b 6 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Mapleville X				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Boonsboro Md. RFD 2					d. STREET ADDRESS Boonsboro Md. RFD #2			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Annie Middle Vass Last Renner					4. DATE OF DEATH Month June Day 18 Year 1961				
5. SEX Female		6. COLOR OR RACE White.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1882 March 3 1883		9. AGE (In years last birthday) 79 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Williamsport Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A		
13. FATHER'S NAME Alex Mc Kelvey					14. MOTHER'S MAIDEN NAME Mary Singer				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None		17. INFORMANT Mapleville Boonsboro Raymond R. Renner Md. RFD #2					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Hypertensive cardiovascular (b) heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 3 yrs									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from Sept. 15, 1960 to June 18, 1961, that (I) (we) last saw the deceased alive on June 18, 1961, and that death occurred at 2 PM, from the causes and on the date stated above.									
22a. SIGNATURE J. W. Lekan					22b. DATE SIGNED June 18, 1961				
22c. PHYSICIAN'S NAME (Type) G. W. Lekan					22d. ADDRESS Boonsboro Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF June 21-61		23c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		23d. LOCATION (City, town, or county) (State) Sharpsburg Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf					25a. REC'D BY REGISTRAR DATE JUN 22 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		

(M)

(I)

CHIEF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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7301
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
07290

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa</u> b. COUNTY <u>Franklin</u> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 yr</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garlock Hospital</u>		d. STREET ADDRESS <u>75X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>T</u> Last <u>RIPPLE</u>		4. DATE OF DEATH Month <u>June</u> Day <u>24</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1881</u>
9. AGE (In years lost birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James W. Ripple</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Doyle</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Minnie Ripple</u>		Address <u>State Line Pa</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of Gall Bladder</u> <u>155.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>None</u> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>August</u> 19 <u>60</u> , to <u>June 24</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>June 23</u> 19 <u>61</u> , and that death occurred at <u>7 P.</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Dr. John D. Turco</u>		22b. DATE SIGNED <u>6-26-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. John D. Turco</u> <u>for Dr. Eldon Hoachlander</u>		22d. ADDRESS <u>302 N. Potomac Street-</u> <u>Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 24/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Lawn</u>		23d. LOCATION (City, town, or county) (State) <u>near Hagerstown Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. E. Munich</u>		ADDRESS <u>Greencastle Pa</u>	
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u>	
DATE <u>JUN 29 '61</u>			

TO BE FILED WITH THE DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7302

07291

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 2 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mt Royal Apts				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 1 Mt Royal Apts e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) MILDRED TEAGUE SCHOEN		4. DATE OF DEATH June 8 1961		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jany 16 1903		9. AGE (In years last birthday) 58		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Balt. Co. Maryland				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Merrill Teague				14. MOTHER'S MAIDEN NAME Ada C. Hair				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. ---				17. INFORMANT Unable to locate sheridan S. Hamilton Address 1407 Oak Hill Ave Hagerstown Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease (a), stating the underlying cause last. DUE TO (c) Indefinite												INTERVAL BETWEEN ONSET AND DEATH 2-3 hours							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---															
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. ---				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ---				20f. (City or town) (County) (State) ---							
21. I certify that (I) (this hospital) attended the deceased from 1950 , to death 1961 , that (I) (we) last saw the deceased alive on June 8, 1961 , and that death occurred at M , from the causes and on the date stated above.																			
22a. SIGNATURE Paul Harrison				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 6-10-61											
22c. PHYSICIAN'S NAME (Type) Paul Harrison, M. D.				22d. ADDRESS 318 N. Potomac St., Hagerstown, Md.															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 6/10/61				23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md							
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md				25a. REC'D BY REGISTRAR DATE JUN 13 '61				25b. REGISTRAR'S SIGNATURE Carlton S. Hanna							

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FOR STATE
HEALTH DEPT.
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TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.
I

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
7303 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 07292

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport	
c. LENGTH OF STAY in 1b 3 hrs.		d. STREET ADDRESS 18 Sunset Ave.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Patricia Shank		4. DATE OF DEATH June 8 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 8 1961
9. AGE (In years last birthday) yrs. 3		10. IF UNDER 1 YEAR Months Days Hours 15	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Henry Shank		14. MOTHER'S MAIDEN NAME Tomasita Montes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Thomas Henry Shank		Address 18 Sunset Ave. Williamsport Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 560.2 DUE TO Complete Pnephatic Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Blue from 9:30 AM died in operating table 2:15 PM			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE J. E. W. WITTOG		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) J. E. W. WITTOG		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF June 9-61	
22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or country) (State) Williamsport Md.	
23. FUNERAL DIRECTOR Albert Leaf Williamsport, Md		24a. REC'D BY REGISTRAR DAN 12 '61	
		24b. REGISTRAR'S SIGNATURE William S. Kline	

M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7304

07293

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>13 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>154 WEST NORTH STREET</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u> d. STREET ADDRESS <u>154 WEST NORTH ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>HELEN D. SHOVE</u>		4. DATE OF DEATH Month <u>JUNE</u> Day <u>29</u> Year <u>1961</u>		5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>APRIL-15-1884</u> 77 yrs.		9. AGE (In years last birthday) <u>77</u> IF UNDER 1 YEAR: Months <u>2</u> Days <u>14</u> Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>NEAR DOWNSVILLE WASH. CO. MD. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>HENRY CLAY BURCAN</u> 14. MOTHER'S MAIDEN NAME <u>MARY VIRGINIA BOWERS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>MISS VERA SHOVE</u> Address <u>154 WEST NORTH ST. HAGERSTOWN MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> (b) <u>Arterio Sclerotic Heart disease</u> (c) <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs</u> <u>10 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (the hospital) attended the deceased from <u>June 27, 1961</u> to <u>June 29, 1961</u> , that (I) (we) last saw the deceased alive on <u>June 27, 1961</u> , and that death occurred <u>June 29, 1961</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>F F Lusby</u>		22b. DATE SIGNED <u>30/4/61</u>		22c. PHYSICIAN'S NAME (Type) <u>F F Lusby</u>			
22d. ADDRESS <u>2301 N Potomac Hagerstown Md</u>		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>July 2, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEMETERY</u>			
23d. LOCATION (City, town or county) <u>HAGERSTOWN WASH. CO. MD.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Bart</u>					
25a. REC'D BY REGISTRAR <u>DATE JUL 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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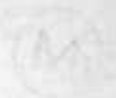
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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I
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington Co</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va.</u> b. COUNTY <u>Hedgesville, Route 2</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hedgesville, Route 2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Williamsport Sanitarium</u>				d. STREET ADDRESS <u>85X-3</u>			
3. NAME OF DECEASED (Type or print) First <u>Rosa</u> Middle <u>Pet</u> Last <u>Shriver</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1961</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 19, 1878</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>3</u> Hours <u>0</u> Min. <u>0</u>		IF UNDER 24 HRS. Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Duties</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Fulton Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Barnhart</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Jordan</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>Mrs. Mary Hedrick, Falling Waters W. Va.</u> Address <u>W. Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0 Congestive Heart failure</u> DUE TO (b) <u>Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>2 days</u> INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>① Cachexia ② Pyoderma</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u>0</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1950</u> to <u>June 16, 1961</u> , that (I) (we) last saw the deceased alive on <u>6-16</u> 19 <u>61</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>M. E. Byrkit</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>6-16-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>M. E. Byrkit</u>				22d. ADDRESS <u>Williamsport, W. Va.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-19-1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Providence Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hedgesville, Rt. # 2, W. Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. Brown</u> ADDRESS <u>Martinsburg, W. Va.</u>				25a. REC'D BY REGISTRAR <u>JUN 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

Blank form with horizontal lines for text entry.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

7306

07295

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R.F.D c. LENGTH OF STAY IN b 5 Wks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Avalon Manor		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 209 West Irvin Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HOWARD ERNEST SLAGEN		4. DATE OF DEATH Month Day Year June 21 1961 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 25 1870
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) College Professor		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Md. New Windsor Carroll Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Slagen		14. MOTHER'S MAIDEN NAME Anna Bange	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs Mabel Kaylor		Address 209 W. Irvin Ave Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchial Pneumonia 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Inanition DUE TO (c) Carcinoma of colon		INTERVAL BETWEEN ONSET AND DEATH 4 days 2 mo. 4 mo +	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 1961 to June 21, 1961 , that (I) (we) last saw the deceased alive on June 21, 1961 , and that death occurred at 11:45 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Clara A. Hoffman M.D.		22b. DATE SIGNED 6/23/61	
22c. PHYSICIAN'S NAME (Type) Clara A. Hoffman		22d. ADDRESS 214 N. Potomac St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/24/61	
23c. NAME OF CEMETERY OR CREMATORY Mt Carmel Cemetery Littlestown Adams Co Pa		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		24a. ADDRESS Hagerstown Md.	
24b. REC'D BY REGISTRAR JUN 26 '61		24c. REGISTRAR'S SIGNATURE Arthur S. Kline	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07296

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> c. LENGTH OF STAY IN 1b <u>55 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>200 E. Main Street</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sharpsburg</u> d. STREET ADDRESS <u>200 E. Main Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Aimee</u> <u>Wilson</u> <u>Smith</u>				4. DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>19 61</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>June 23 1905</u>			
9. AGE (In years last birthday) <u>55</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>23</u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (County & State, or foreign country) <u>Sharpsburg Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>Victor Smith</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Wilson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Grafton V. Smith</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO (b) <u>Arteriosclerotic Cardio-Vascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u>61</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) <u>Sharpsburg Md.</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 6 - 10 1961</u> to <u>Jan. 16 1961</u> , that (I) (we) last saw the deceased alive on <u>Jan. 9 1961</u> , and that death occurred at <u>9:59 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Walter H. Shealy</u> M.D.				22b. DATE SIGNED <u>6-18-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>WALTER H. SHEALY</u>				22d. ADDRESS <u>Sharpsburg Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>June 19-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. View Cemetery</u>			
23d. LOCATION (City, town or county) (State) <u>Sharpsburg Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 20 '61</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert Leaf Williamsport, Maryland</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneass</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

7308

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

07297

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
c. LENGTH OF STAY IN 1b <u>15 yrs</u>		d. STREET ADDRESS <u>1910 Virginia Ave.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1910 Virginia Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Geary</u> Middle <u>W.</u> Last <u>Snyder</u>		DATE OF DEATH Month <u>June</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 2, 1868</u>
9. AGE (In years lost birthday) <u>93</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John W. Snyder</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Ellen Zentger</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT Address <u>Mrs. Leila M. Schaffer, Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c) <u>General arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>Indefinite</u> <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Prostatic hypertrophy benign</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5:40 P.</u> to <u>June 16</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>May</u> 19 <u>61</u> and that death occurred at <u>M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>B.B. Kneisley</u>		22b. DATE SIGNED <u>6/17/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>B.B. Kneisley, M.D.</u>		22d. ADDRESS <u>148 West Washington Street Hagerstown, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6-19-1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Hagerstown, Washington Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harold M. Zimmerman, Hagerstown, Pa</u>		25a. REC'D BY REGISTRAR <u>DATE JUN 20 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u>	

07201

CERTIFICATE OF DEATH

1907

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... cause of death ...
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7309 CERTIFICATE OF DEATH 07298											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 19 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 133 Summit Ave.						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 133 Summit Ave. a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) IRMA			First ELAINE			Middle SOUTH			Last		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 17, 1898		9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months 14 Days 14 Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Midland, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Thomas						14. MOTHER'S MAIDEN NAME Annie E. Askie					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Frank P. South Address Hagerstown, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Acute Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Advanced Arteriosclerotic heart disease + Coronary atherosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Apr 26, 1961 to June 14, 1961 , that (I) (we) last saw the deceased alive on May 34, 1961 , and that death occurred at 4:30 PM , from the causes and on the date stated above. 22a. SIGNATURE Edward W. Ditto III, M.D. 22b. DATE SIGNED 6/14/61 22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D. 22d. ADDRESS 217 West Washington St.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6/17/1961			23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City, town or county) (State) Cumberland, Maryland		
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home ADDRESS Hagerstown, Maryland						25a. REC'D BY REGISTRAR JUN 16 '61			25b. REGISTRAR'S SIGNATURE Arthur S. Kline		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
7310													
CERTIFICATE OF DEATH													
07299													
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 3 c. LENGTH OF STAY IN b 38 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Funkstown						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 3 d. STREET ADDRESS Funkstown e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Rev. SYRON FREDERICK SPITZER						4. DATE OF DEATH Month Day Year June 8 1961 19							
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept 13 1877		9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days 83			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Wood Work				11. BIRTHPLACE (County & State, or foreign country) Broadway Rockingham Co Va.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Franklin P. Spitzer						14. MOTHER'S MAIDEN NAME Lydia Holsinger							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No						16. SOCIAL SECURITY NO. ---						17. INFORMANT Carroll F. Spitzer Hagerstown R # 3 Address Funkstown	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Ephemeral Pneumonia 450.0 DUE TO Acute Suppurative Parotiditis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO Atherosclerosis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 hrs. 4 days. years.													
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)													
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)													
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		20g. (County)		20h. (State)			
21. I certify that (I) (this hospital) attended the deceased from 1955 to 6-8-61 , that (I) (we) last saw the deceased alive on 6-8-61 , and that death occurred at 12 M, from the causes and on the date stated above.													
22a. SIGNATURE D. J. Boyer						22b. DATE SIGNED 6-9-61							
22c. PHYSICIAN'S NAME (Type) Dr D. J. Boyer						22d. ADDRESS No Potomac st Hagerstown Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/10/61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash co Md.							
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.						25a. REC'D BY REGISTRAR JUN 13 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kians					

VR A15 (4)
15M 9/60

2282

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

7311

CERTIFICATE OF DEATH

07300

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY in 1b 30 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 173 Summit Ave		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 173 Summit Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ELSIE MAY STARLIPER		4. DATE OF DEATH Month Day Year June 30 1961 19				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 15 1886	9. AGE (In years last birthday) 75 yrs.	IF UNDER 1 YEAR Months Days 75	IF UNDER 24 HRS. Hours Min. 75
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Little Cove Penna		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Starliper		14. MOTHER'S MAIDEN NAME Malinda Cousins				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Frank Carty Hagerstown Md. R # 3		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO arterio sclerotic heart disease with myocardial failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 yrs +		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (in hospital) attended the deceased from Jan 1956 to June 30 1961 , that (I) (no) last saw the deceased alive on June 29 1961 , and that death occurred ASCA from the causes and on the date stated above.						
22a. SIGNATURE F F Lusby		M.D. F F Lusby		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 235 N Polman St		22b. DATE SIGNED 30 6 61
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/2/61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown M.d				25a. REC'D BY REGISTRAR JUL 5 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines

07800

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(M)

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THESE ARE THE
ORIGINALS OF THE
DOCUMENTS

FF-100
FF-100
FF-100

CONFIDENTIAL

TO HAVE NO EFFECT OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased is not a resident of the State, the certificate may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7312											
Item 23b, Film G288 6/14/61 jwk											
07301											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 30 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 235 N. Cleveland Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First CESARIO Middle STIVALETTI Last STIVALETTI						4. DATE OF DEATH Month June Day 7 Year 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 4, 1896		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65 Hours 65 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Quarry Worker						10b. KIND OF BUSINESS OR INDUSTRY Cement Company		11. BIRTHPLACE (County & State, or foreign country) Vasto, Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Joseph Stivaletti						14. MOTHER'S MAIDEN NAME Rosa Chiciquina					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)						16. SOCIAL SECURITY NO. 213-10-6869		17. INFORMANT Mrs. Albert J. DeBiase Address Hagerstown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary artery sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none INTERVAL BETWEEN ONSET AND DEATH 9 hr											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 6/7 , 19 61 , to 6/7 , 19 61 , that (I) (we) last saw the deceased alive on 6/7 , 19 61 , and that death occurred at 3:30 PM , from the causes and on the date stated above.											
22a. SIGNATURE Robert Vh Campbell M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/9/61			
22c. PHYSICIAN'S NAME (Type) Robert T Vh. Campbell						22d. ADDRESS Hagerstown Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 6/ 10, 1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill cemetery		23d. LOCATION (City, town or county) Hagerstown, Maryland (State)					
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home R. J. Hamilton Rouzer						ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JUN 12 '61		25b. REGISTRAR'S SIGNATURE Clifton S. Kraus	

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Washington

Hagerstown

Washington County Hospital

Clarke

White

Retired Army Major

Joseph Stivala

10 years

10 years

325 N. Maryland Ave.

STIRLING

April 1, 1930

Vanoy, Italy

John Chickama

27-10-3000 Mrs. Albert J. Deane Hagerstown, Md.

27-10-3000 Mrs. Albert J. Deane Hagerstown, Md.

27-10-3000 Mrs. Albert J. Deane Hagerstown, Md.

Robert L. Campbell
Hagerstown, Md.
April 1, 1930

Robert L. Campbell
Hagerstown, Md.
April 1, 1930

Robert L. Campbell
Hagerstown, Md.
April 1, 1930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DR. DITTO

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
7313											
CERTIFICATE OF DEATH											
07302											
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BENEVOLA 'RURAL'					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN 10 HOURS -						d. STREET ADDRESS 1 BEANSBORO MD. R. 1					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASH. CO. HOSPITAL						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) RENO VERDEEN STOFFER		First Middle Last		4. DATE OF DEATH JUNE - 11 - 1961		Month Day Year					
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MAY - 24 - 1883		9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REAL ESTATE APPRAISER						10b. KIND OF BUSINESS OR INDUSTRY BENEVOVA WASH. CO. MD. U.S.A.					
11. BIRTHPLACE (County & State, or foreign country)						12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME ARTHUR M. STOFFER						14. MOTHER'S MAIDEN NAME SARAH JANE FASNACHT					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO						16. SOCIAL SECURITY NO. 217-10-3069A					
17. INFORMANT HARRY NEWCOMER						Address REGISTER OF WILLS HAGERSTOWN MD.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5400 Massiv hemorrhage from large artery ulcer - DUE TO (b) gastric ulcer - DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General arteriosclerosis - Benign prostatic hypertrophy											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 8, 1958, to June 11, 1961, that (I) (we) last saw the deceased alive on June 11, 1961, and that death occurred at 4 PM, from the causes and on the date stated above.											
22a. SIGNATURE Edward W. Ditto III, M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6/13/61			
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D.						22d. ADDRESS 217 West Washington St.					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF JUNE-14-1961		23c. NAME OF CEMETERY OR CREMATORY FAHRNEYS CEMETERY		23d. LOCATION (City, town or county) (State) NR. MAPLEVILLE WASH. CO. MD.					
24. FUNERAL DIRECTOR'S SIGNATURE John V. Ball						ADDRESS BOONSBORO MD		25a. REC'D BY REGISTRAR DATE JUN 16 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	



VS. AISME
5M 9/60

MEDICAL CERTIFICATION	1. PLACE OF DEATH a. COUNTY Washington	2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland	b. COUNTY Washington				
	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b 3 month	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg	d. STREET ADDRESS 220 W. Chapel Street			
	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Western Md. State Hospital	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
	3. NAME OF DECEASED (Type or print) Sarah C Swain	4. DATE OF DEATH June 10 1961					
	5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21 1877	9. AGE (In years last birthday) 83 yrs.	IF UNDER 1 YEAR Months 7 Days 19	IF UNDER 24 HRS. Hours Min.
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A			
	13. FATHER'S NAME William Showe	14. MOTHER'S MAIDEN NAME Amelia Mc Coy					
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No	16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. Autumn L. Kaiss	Address Hagerstown Md.			
	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Decompensation Due To General Arterio-sclerosis, Severe 902.7 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c) Fracture Of Pelvis (2-5-61) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Patient confused climbed over side rails of bed falling to floor.	INTERVAL BETWEEN ONSET AND DEATH Recent 4 months					
	20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) Patient fell from hospital bed.	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 2-5- 1961	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hospital	20f. (City or town) Hagerstown, Washington, Md.	(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ACTUAL SIGNATURE <i>E. W. Ditto, Jr.</i> M.D. EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr. Address (Street, city, town, or county) 6-10-61	DATE SIGNED 6-10-61						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF June 12-61	22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	22d. LOCATION (City, town, or country) Sharpsburg Md.	23. FUNERAL DIRECTOR Albert L. Leaf Williamsport Md.	24a. REC'D BY REGISTRAR DATE JUN 13 '61	24b. REGISTRAR'S SIGNATURE Charles E. Evans	

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Handwritten signature
J. Edgar Hoover
Director

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7315

07304

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural 2 Williamsport</u>			
c. LENGTH OF STAY IN 1b <u>2 wks. 1 day</u>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>				f. STREET ADDRESS <u>RFD #2</u>			
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>Willie</u> Last <u>Thomas</u>				4. DATE OF DEATH Month <u>6</u> Day <u>30</u> Year <u>1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/31/1886</u>	
9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>Page Co., Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Taylor</u>				14. MOTHER'S MAIDEN NAME <u>Anna B. Dean</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Sylvester A. Furtado</u> Address <u>118 W. Salisbury St. Williamsport Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Ac myocardial infarction due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Williamsport</u> (County) <u>Washington</u> (State) <u>Md.</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>6/30/61</u> to <u>6/30/61</u> , that (I) (we) last saw the deceased alive on <u>6/30/61</u> , and that death occurred at <u> </u> M. from the causes and on the date stated above.							
22a. SIGNATURE <u>[Signature]</u>				22b. DATE SIGNED <u>6/30/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>				22d. ADDRESS <u> </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/3/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		23d. LOCATION (City, town, or county) <u>Williamsport, Md</u> (State) <u>Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Green</u>				25a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>JUL 5 '61</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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CERTIFICATE OF DEATH

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Copy of
Certificate of Death
for [illegible]
dated [illegible]
at [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

7316

07305

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> c. LENGTH OF STAY IN 1b <u>7 WKS</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>W. MD. STATE HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parale md. 01X-2</u> d. STREET ADDRESS <u>National Hwy.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Georgie Frances Wagner</u>			4. DATE OF DEATH Month Day Year <u>June 19, 1961</u>				
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 14 - 1891</u>	9. AGE (In years last birthday) <u>70</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED NURSE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Cumberland Md.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>HARRY WAGNER</u>			14. MOTHER'S MAIDEN NAME <u>ELIZABETH ALLEN</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Hospital Records -</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary arteriosclerosis</u> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>one day</u> <u>unknown</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, Arteriosclerosis obliterans, legs</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>April 26, 1961</u> to <u>JUNE 19, 1961</u> , that (I) (we) last saw the deceased alive on <u>JUNE 19, 1961</u> , and that death occurred at <u>11:58 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Young E. Chun</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> <u>June 20, 1961</u>	22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>		22d. ADDRESS <u>Western Maryland State Hospital Hagerstown, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>6-22-61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill - Cumberland</u>	23d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>				
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hager Funeral Service</u>		ADDRESS <u>Cumberland Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 22 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		

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CERTIFICATE OF DEATH

Reg. Dist. No. 07306

7317

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wash.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>				d. STREET ADDRESS <u>Hamilton Hotel - W.Wash. St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Albert</u> Middle <u>Wesley</u> Last <u>Warrenfeltz</u>				4. DATE OF DEATH Month <u>June</u> Day <u>3</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1883</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>78</u> Days <u>03</u>	IF UNDER 24 HRS. Hours <u>03</u> Min. <u>00</u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Day laborer(farm)</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick County Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Solue Warrenfeltz</u>				14. MOTHER'S MAIDEN NAME <u>Clara Palmer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-34-9346</u>		INFORMANT <u>Mrs. Dora Abdullah, 836 Virginia Ave. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Nephro-sclerosis Arteriolar, right</u> DUE TO (c) <u>Non-functioning left Kidney</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <u>6 yrs.</u> <u>1 yr.</u> <u>?</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <u>Philip J. Hirshman</u> attended the deceased from <u>6/17/59</u> , 19 <u>61</u> , to <u>June 3rd, 1961</u> , that I last saw the deceased alive on <u>June 3rd, 1961</u> , and that death occurred at <u>2:45 P.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>159 W. Washington St., Hagerstown, Maryland</u> DATE SIGNED <u>6/3/61</u>							
ACTUAL SIGNATURE <u>Philip J. Hirshman</u>		M.D. <u>159 W. Washington St., Hagerstown, Maryland</u>					
PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 6, 1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. John's Luth.</u>		22d. LOCATION (City, town, or county) (State) <u>Myersville, Fred. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul R. Bittle</u>				24a. REC'D BY REGISTRAR DATE <u>JUN 6 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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7318
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07307

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL 2, CLEAR SPRING c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RESIDENCE			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL 2, CLEAR SPRING, MD. d. STREET ADDRESS NONE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last BESSIE ELIZEBETH WEAVER			4. DATE OF DEATH Month Day Year JUNE 7, 1961		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH JUNE 20, 1880		9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		12. KIND OF BUSINESS OR INDUSTRY HOME DUTIES		13. BIRTHPLACE (State or foreign country) WASHINGTON CO. MD.	
14. CITIZEN OF WHAT COUNTRY? U.S.A.		15. FATHER'S NAME BERKLEY ROHRER		16. MOTHER'S MAIDEN NAME ELIZEBETH MARTIN	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		18. SOCIAL SECURITY NO. NONE		19. INFORMANT Address HARRY C. WEAVER RD. 2, CLEAR SPRING, MD.	
20. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION DUE TO CORONARY ARTERY OCCLUSION 420.0 DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) unknown INTERVAL BETWEEN ONSET AND DEATH 10 minutes					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
22a. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		22b. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		22c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (County) (State)	
23. I certify that (I) (this hospital) attended the deceased from January 7, 1960 to June 7, 1961 , that (I) (we) lost saw the deceased alive on June 6, 1961 , and that death occurred at 1:00 AM , from the causes and on the date stated above.					
24a. SIGNATURE Archie Robert Cohen M.D.		24b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		24c. DATE 06/07/61	
24d. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.		24e. ADDRESS Clear Spring, Maryland			
25a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		25b. DATE THEREOF JUNE 9, 1961		25c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	
25d. LOCATION (City, town, or county) CLEAR SPRING, MD.		25e. (State)			
26a. FUNERAL DIRECTOR'S SIGNATURE John F. Clark		26b. ADDRESS CLEAR SPRING, MD.		26c. REC'D BY REGISTRAR JUN 12 '61	
26d. REGISTRAR'S SIGNATURE Arthur S. Kraus		26e. DATE			

CERTIFICATE OF DEATH

(M)

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ATTEST: COUNTY CLERK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07308

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Western Maryland Hosp.</u>				d. STREET ADDRESS <u>240 N. Centre St.</u>			
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>EMMA</u> Last <u>WINTERBERG</u>				4. DATE OF DEATH Month <u>JUNE</u> Day <u>18</u> Year <u>1961</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 24, 1895</u>	9. AGE (In years last birthday) <u>86</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Hooftman Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>Richard Hendray</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Reisl.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs. Hazel Spittle Balto Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CARCINOMATOSIS</u> DUE TO (c) <u>CARCINOMA OF LEFT BREAST</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6-DAYS</u> <u>UNKNOWN</u> <u>20 MONTHS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>3-15</u> 19 <u>61</u> , to <u>6-18</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>6-18</u> 19 <u>61</u> , and that death occurred at <u>7:50</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Antonio U. Pallabrosi</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO U. PALLABROSI</u>				22d. ADDRESS <u>1500 PENNA AVE HAGERSTOWN MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/21/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc - Cumb. Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUN 21 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur E. Kraus</u>	

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CHIEF CLERK

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

07309

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 1770 GILBERT AVE.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last MARGARET RUTH YEATES				4. DATE OF DEATH Month Day Year JUNE 5 19 61			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/2/1898	9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM CLAPSADDLE				14. MOTHER'S MAIDEN NAME LAIRA CRIDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 214-28-1107		17. INFORMANT MR. CHESTER L. YEATES		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA AND CONGESTION 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE DUE TO (c) 92 years						INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 27 19 61 , to JUNE 5 19 61 , that (I) (we) last saw the deceased alive on JUNE 5 19 61 , and that death occurred at 11:55 AM , from the causes and on the date stated above.							
22a. SIGNATURE E. R. Landizabal				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 6-6-61	
22c. PHYSICIAN'S NAME (Type) E. R. Landizabal				22d. ADDRESS Smithsburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 6/8/61		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.		23d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant				25a. REC'D BY REGISTRAR DATE JUN 8 1961		25b. REGISTRAR'S SIGNATURE Arthur S. Hous	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE BOARD OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Downsville</u>			c. LENGTH OF STAY IN 1b <u>4 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Downsville</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Woburn Manor Boarding Home</u>					d. STREET ADDRESS <u>Williamsport RFD #2</u>				
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Henry</u> Last <u>Young</u>					4. DATE OF DEATH Month <u>June</u> Day <u>2</u> Year <u>1961</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 30, 1868</u>		9. AGE (In years last birthday) <u>93</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sexton</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cemetery</u>		11. BIRTHPLACE (State or foreign country) <u>Washington County</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Jeremiah Young</u>					14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Thomas</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Name <u>William T. Young</u> Address <u>1723 Virginia Ave. Hagerstown, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Heart and circulatory system</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____		
21. I certify that (I) (this hospital) attended the deceased from <u>6/2/61</u> to <u>6/2/61</u> , that (I) (we) lost saw the deceased alive on <u>6/2/61</u> , and that death occurred at _____ M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Ralph Young</u>					22b. DATE SIGNED <u>6/3/61</u>				
22c. PHYSICIAN'S NAME (Type) <u>Ralph Young</u>					22d. ADDRESS <u>Williamsport, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>June 5, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Manor Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>Near Tilghmanton, Md.</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert L. Legg Williamsport, Md.</u>					25a. REC'D BY REGISTRAR DATE <u>JUN 6 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		

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